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SOCIAL SERVICE INVESTIGATION
AS AN AID TO
SELECTIVE SERVICE NEUROPSYCHIATRY

AN EXPERIMENTAL STUDY OF SOCIAL HISTORIES
ON A HUNDRED TEMPORARY REJECTES
MASSACHUSETTS, 1942

A Thesis

11

Submitted by

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In Partial Fulfillment of Requirements for the
Degree of Master of Science in Social Service

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TABLE OF CONTENTS

CHAPTER	PAGE
I INTRODUCTORY	1
II IMPORTANCE OF ELIMINATING NEUROPSYCHIATRIC CASUALTIES FROM THE ARMY	3
Psychologic hazards of military service	3
In training	3
In combat	6
Consequences of inducting martial misfits	8
To individuals concerned and to their communities	8
To military efficiency and morale	12
Statistical evidence from the last war	14
III ATTEMPTS AT ELIMINATING MARTIAL MISFITS BEFORE INDUCTION	17
The selective service neuropsychiatric examination system in the last war	17
The late start	17
Nature of the examination system	18
Weaknesses in the system	19
The changes in neuropsychiatric thinking since the last war	20
New conditions of warfare	21
New emphasis in neuropsychiatric thinking	22
Selective service neuropsychiatric examination system in this war	23
Development	24
Current organizational structure	28
Diagnostic criteria and techniques of examination	29

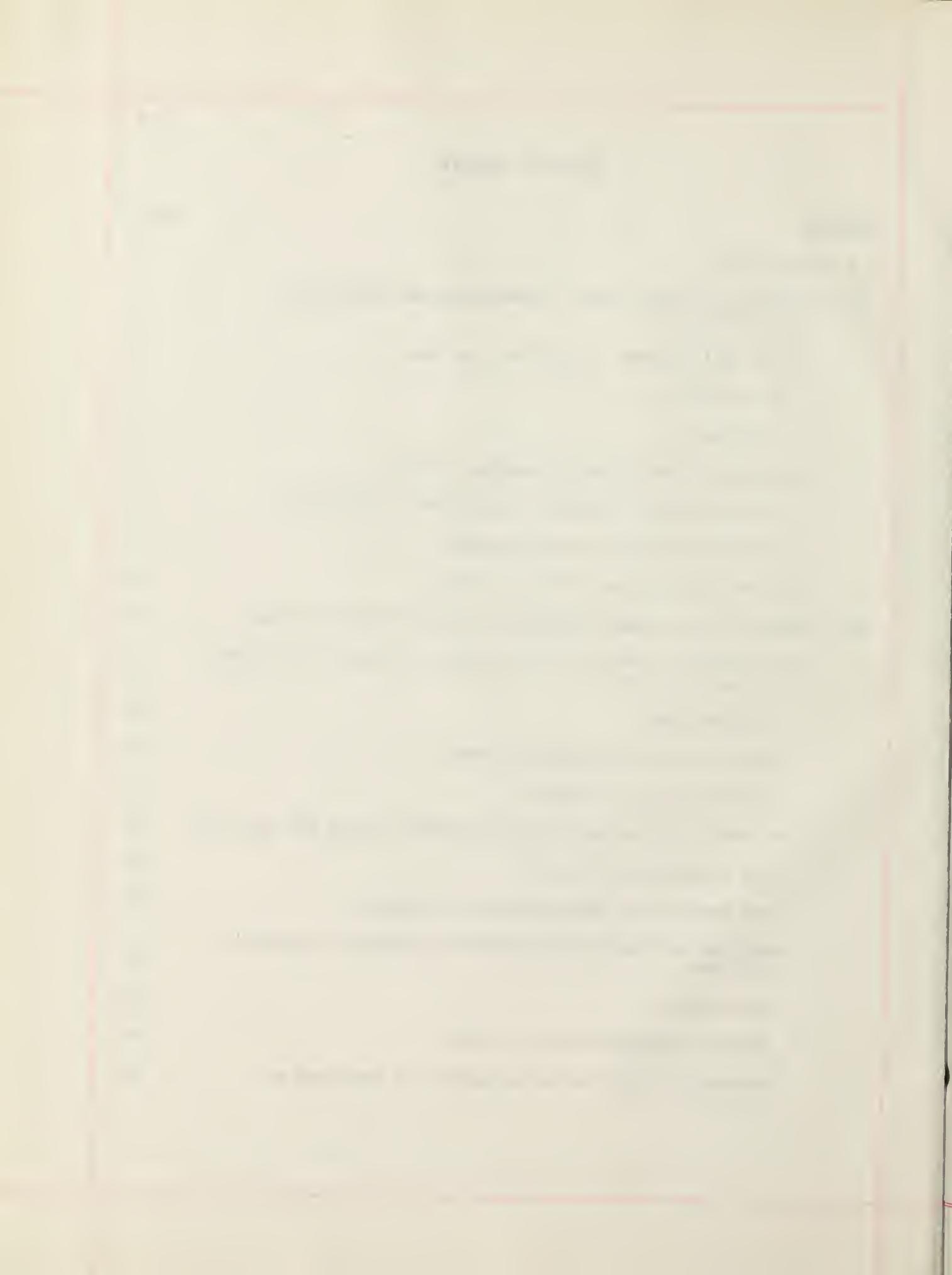
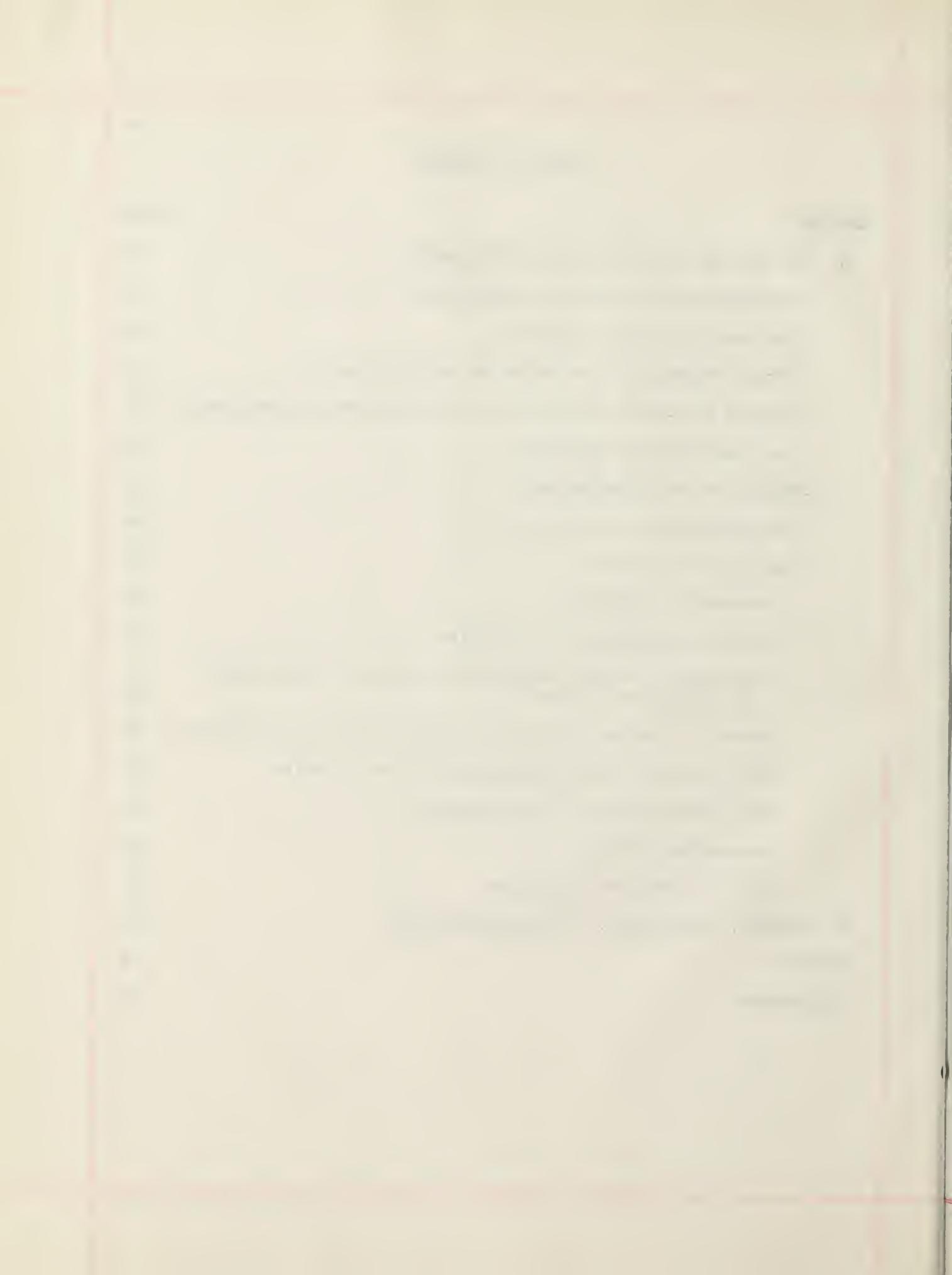


TABLE OF CONTENTS

CHAPTER	PAGE
IV THE NEED FOR SOCIAL SERVICE INVESTIGATION	35
Difficulties in detecting disabilities	35
The need for social histories	36
Recent evidences of the value of social histories	37
Current experiments in the use of social service investigation	39
The Massachusetts experiment	41
V ANALYSIS OF THE RECORDED DATA	45
Data available to investigator	45
Analysis of the data	46
Reasons for referral	46
Age and geographical distribution	47
Relationship between availability of agencies and number of cases known to them	50
Amount of service provided by social agencies to these cases	54
Data gathered through Department of Mental Health	56
Data from police and court records	56
Evaluation of data	57
Need for personal interviews	60
VI SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS	62
APPENDIX	65
BIBLIOGRAPHY	74



LIST OF TABLES AND ILLUSTRATIONS

TABLE	PAGE
I Neuropsychiatric Hospital Admissions in American Army, April 1, 1917 to December 31, 1919	14
II A.E.F. Neuropsychiatric Casualties Returned Prior to June 30, 1919	15
III Causes of Neuropsychiatric Rejections in the Last War	19
IV Reasons for Referral of Men for Social Service Investigation	47
V Analysis of Four Categories of the Reasons for Referral	48
VI Age Distribution of Selectees	49
VII Distribution of Men Among Local Boards	49
VIII Number of Selectees and Families Known to Social Agencies	50
IX Size of Population in Selectees' Home Towns	51
X Percentage of Cases Known to Social Agencies	52
XI Percentage of Selectees Known to Department of Mental Health and to Probation Commission	53
XII Number of Contacts with Agencies	54
XIII Number of Public and Private Agencies Known	55
XIV Types of Agencies, Number of Families Known to Them, and Number of Contacts	55
XV Frequency of the Various Types of Conclusive Evidence	58
XVI Types of Suggestive Evidence	59
XVII Unconfirmed Reasons for Referral	60
FIGURE	
1 Major Categories of Neuropsychiatric Disabilities	25
2 Conclusive Evidence Found on 21 Selectees	58



LIST OF TABLES AND ILLUSTRATIONS

IN APPENDIX

FIGURE	PAGE
3 First Explanatory Letter Sent to Social Agencies	66
4 Second Letter Sent to Social Agencies	69
5 Working Notes	70
6 Record Form Kept on Each Case	72
7 Sample of Report Sent to Lt.-Colonel Currier	73



PREFACE

The investigator wishes to acknowledge his debt of gratitude to Miss Marian M. Wyman, Case Consultant of the Boston Family Welfare Society, and Director of the Psychiatric Social Work Unit which conducted the investigation herein described.

Miss Wyman initially inspired this thesis study, contributed the raw social data on which it is based, and was of constant assistance to the investigator throughout the development of the thesis project.



When thou goest forth to battle
against thine enemies . . . the officers
shall speak unto the people, saying . . .
"What man is there that is fearful and
faint-hearted? let him go and return unto
his house, lest his brethren's heart melt
as his heart."

--Deuteronomy 20, 1-8.



CHAPTER I

INTRODUCTORY

The purpose of this study is to determine the value to selective service induction board neuropsychiatric examiners of a psychiatric social work investigation of recorded data as an aid in detecting potential mental and neurologic casualties before induction into the Army.

Such an investigation was recently authorized by the Chief Medical Officer of the Massachusetts State Selective Service Board, and was carried out by a group of competent psychiatric social workers under the auspices of the New England Division on Psychiatric Social Work. During an experimental one-month period, the social workers were asked to compile, from available recorded data, social histories on registrants temporarily rejected on neuropsychiatric grounds. These social histories, when completed, were assigned to the present investigator by the director of the social work project for the purpose of study and analysis aimed at measuring the diagnostic value, if any, of this material. The results of this study are embodied in this thesis.

The extent to which the social service investigation mentioned above was of value in helping to determine the final disposition of these cases by the selective service boards cannot, unfortunately, be included in this study as the final dispositions will not be made for an indefinite period of time. In lieu of this information, the study includes the carefully considered recommendations for disposition made by the director of the social work project on the basis of the facts contained in these social histories. Since these recommendations were made by



psychiatric social workers of considerable technical competence and experience, they should admirably serve the purposes of this study.

The validation of this study is not here attempted, since it is treated at some length in the body of the thesis.



CHAPTER II

IMPORTANCE OF ELIMINATING POTENTIAL NEUROPSYCHIATRIC CASUALTIES FROM THE ARMY

I PSYCHOLOGIC HAZARDS OF MILITARY SERVICE

War has always made great demands on the mental and nervous structure of the men in service. Modern war, with its emphasis on speed, mobility, mechanization, and its use of fear-instilling and morale-shattering devices, makes far greater demands on military personnel, hence requires men physically, mentally, and morally of superior calibre. Men of inferior calibre cannot stand up under the strains and stresses of military service.

These strains and stresses divide themselves into two categories: those involved in the type of life into which a militarized civilian is rather abruptly thrown, and those resulting directly from active combat. A brief review of some of the psychologic hazards entailed in military service during the training period and those related to actual combat may reveal some common causes of tension.

A. IN TRAINING

As soon as a selectee is inducted into the Army, his mode of living changes. He undergoes separation from his family, a change of occupation, and a new form of discipline often involving numerous meaningless, petty restrictions with no chance to retaliate.¹ A large number

¹ Emanuel Miller, ed., The Neuroses in War (New York: The MacMillan Company, 1940), p.4.



of prohibitions are placed on the soldier in order that mass living may be tolerable. Changes in habit routine are distinct psychologic hazards to the individualist of civil life.² The German Army, too, has recognized that the changed mode of living, eating, sleeping, and sexual habits would force the conscripts to undergo initial mental suffering.³ This suffering is increased with many soldiers by the complete exclusion of individuality in a mass experience.⁴ The German Army considered one of the chief psychological problems in conscription to be the reluctance of the civilian to subordinate himself and the fear that the Army would divest him of his personality.⁵

New experiences such as promotion for one who can't assume the added responsibility, or a homosexual assault or invitation may induce a retreat to alcohol, an anxiety state, or an orgy of self-condemnation.⁶ The loss of contact with home as the soldier nears the front, the severe conflict over the need to kill, and the expectation of action (which in the last war brought on the so-called anticipation neuroses) all create considerable anxiety in the new soldier.⁷

So much for the average soldier. It need hardly be stressed that these problems become greatly intensified for the soldier who found difficulty in trying to adjust successfully even in civil life. With such men, and there are many of them in the Army, the very event of being

2 William C. Porter, "Military Psychiatry and the Selective Service," War Medicine, 1:365, May, 1941.

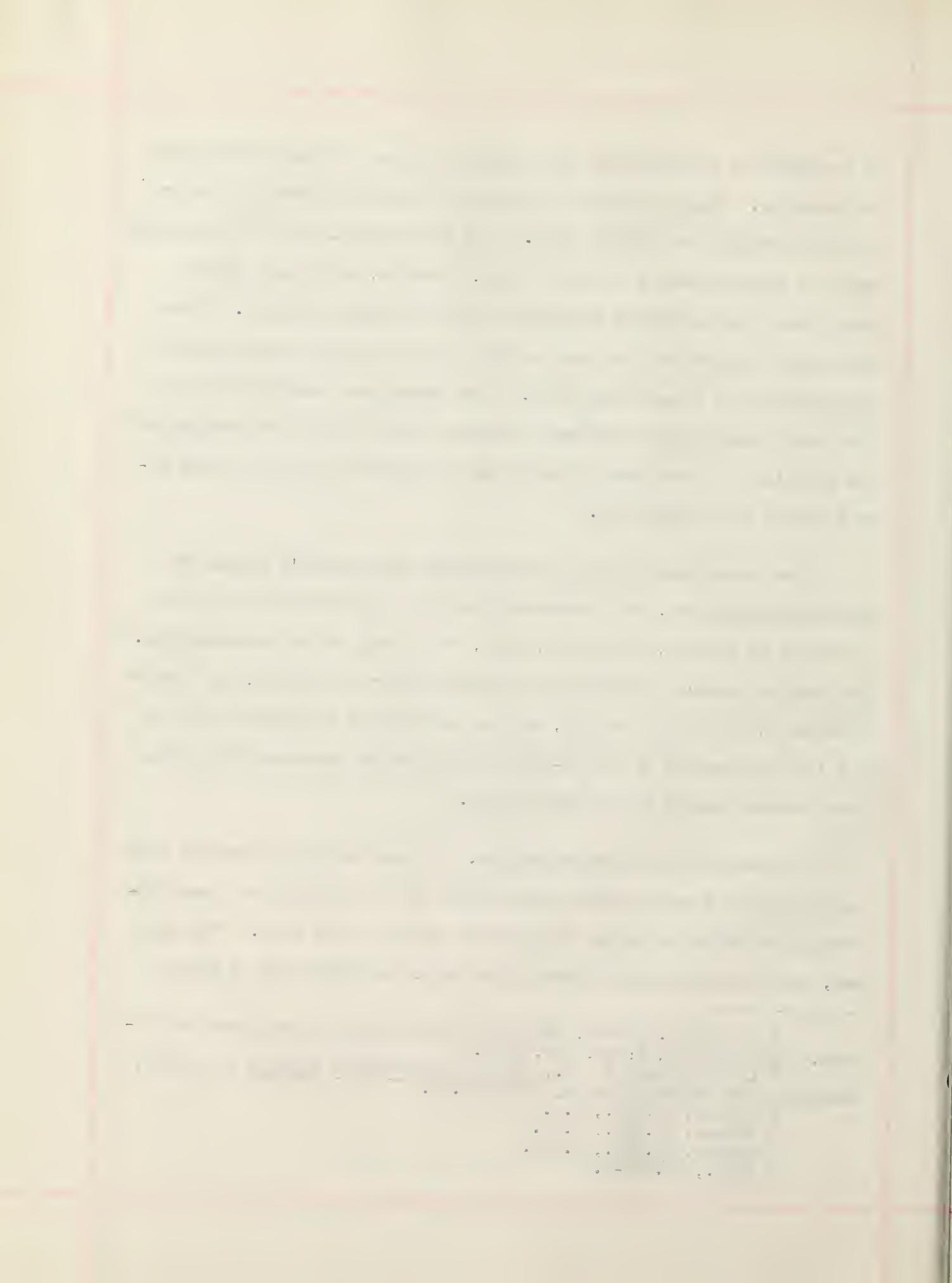
3 Ladislas Farago, ed., German Psychological Warfare (New York: Committee for National Morale, 1941), p.38.

4 Miller, op.cit., p.4.

5 Farago, op.cit., p.37.

6 Porter, op.cit., p.367.

7 Ibid., pp.365-6.



inducted may have disastrous effects.⁸ Mobilization precipitates among them many nervous symptoms, especially functional gastric and cardiac disorders, enuresis, sleep disturbances, and anxiety states.⁹ For such men the disciplinary regime of the Army with its unconcern for the person, its heartless ridicule of the peculiar, and its intolerance of the misfit is difficult to endure.¹⁰ With some of them the intense anxiety about living in intimate contact with others, fear of ridicule, anticipation of taunts about courage or manhood or sexual powers, may precipitate panic or a catatonic state. Barrack mates will not be very tolerant of their eccentricities and props. Ashamed to have them known, exposed to ridicule if observed by others, these men are under great pressure. This pressure often has a tragic outcome.¹¹

A well-known psychiatrist has expressed this thought most lucidly:

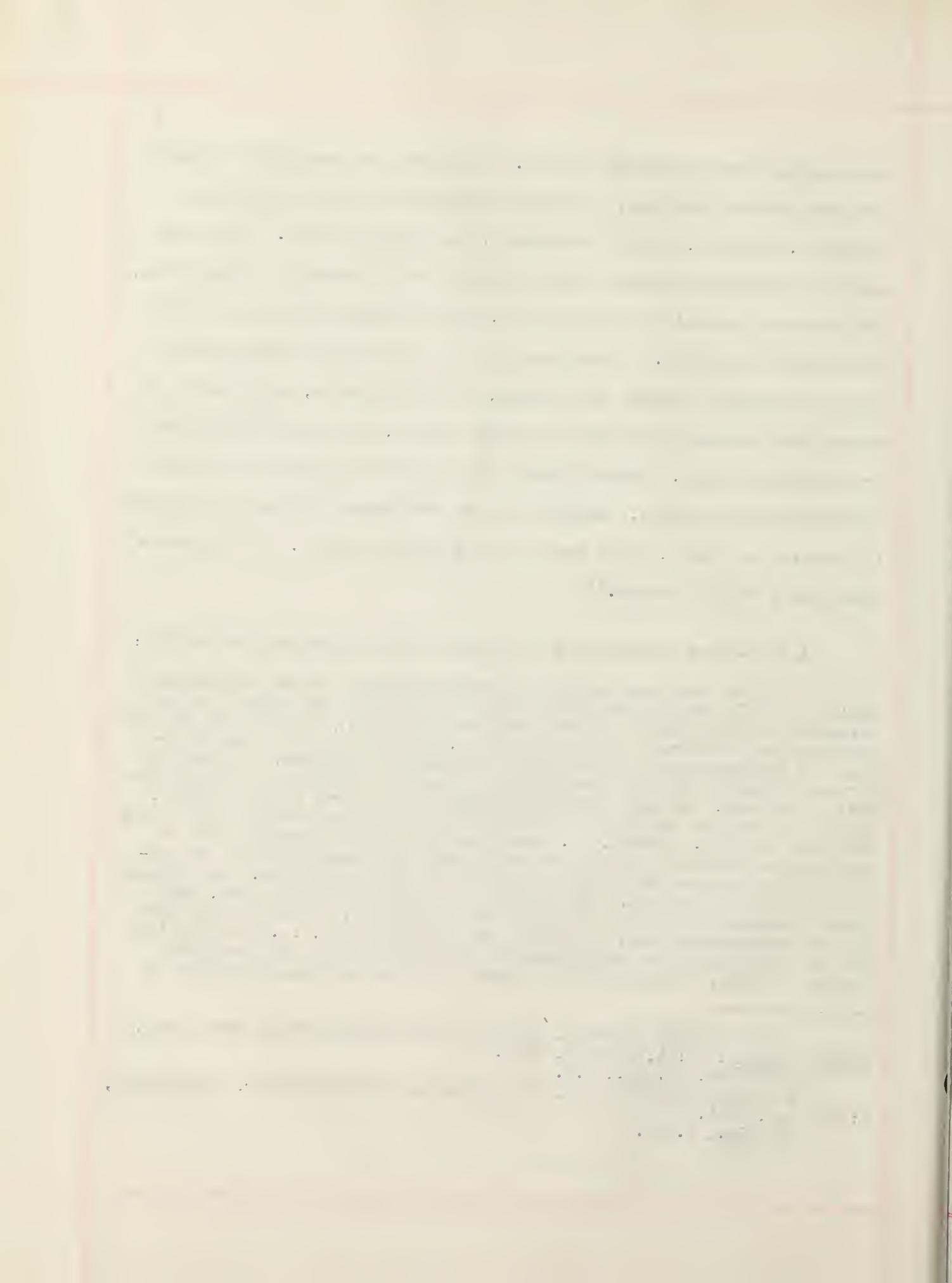
There are many persons in every community who are capable of making a fairly satisfactory adult social adjustment only under the most favorable circumstances, and with extreme difficulty. Because of certain inadequacies of character and personality, life presents to them struggles and complexities of which their fellowmen are unaware. By means of fortunate changes in their environment, opportune withdrawals from difficult situations, and many other expedients not required by most people, those with serious defects in adaptation manage to get along in civil life with fair success. Others. . . escape serious mishap through a lot of charitable allowances on the part of persons with whom they come in contact and the support of these persons in critical situations. In military life such aid is lacking. The soldier who, with much assistance, only barely succeeds in making a satisfactory adjustment, is here thrown upon his own meager resources. All kinds of personalities . . . must fit into the one iron mold which experience has shown to be best for the stern business of war. The result is a heavy incidence of those varieties of

⁸ Harry Stack Sullivan, "A Year of Selective Service Psychiatry," Mental Hygiene, 26:11, January, 1942.

⁹ Miller, op.cit., p.4.

¹⁰ Dexter Means Bullard, "Selective Service Psychiatry," Psychiatry, 4:236, May, 1941.

¹¹ Ibid., p.284.



mental shipwreck that we call psychoses and neuroses, and the merciless disclosure of a large number of constitutionally inferior persons.¹²

Finally, the gravity of these psychologic hazards is revealed in the fact that in the American peacetime Army of volunteers in 1938, 17.52 of every thousand men acquired neuropsychiatric disorders. In a peacetime Army of a million-and-a-half men, at least 27,250 neuropsychiatric casualties a year must be anticipated.¹³ In our currently proposed wartime Army of three million men, it might reasonably be expected that this figure would be at least doubled.

B. IN COMBAT

The severest hazards are those associated with active combat, which, it must be remembered, are superimposed on the training hazards. Some of the common sources of mental stress in the front line are: fear of death or mutilation, guilt over killing, increased responsibility of officers in combat, separation from families, sexual deprivation, inactivity under fire, prolonged uncertainty, fear of land mines,¹⁴ isolation, exposure to protracted bombardment, superstition, surprise, deficiencies and changes in command, and defeat.¹⁵ Fatigue, exhaustion (physical or mental in origin), exposure to inclement weather, loss of sleep, lack of food or water may disturb the delicately balanced mental state of the front line soldier.¹⁶ He often experiences intense anxiety due to the conflict over the deep, unconscious sadistic impulses whose expression is now socially sanctioned; he fears the possibility of unrestrained ag-

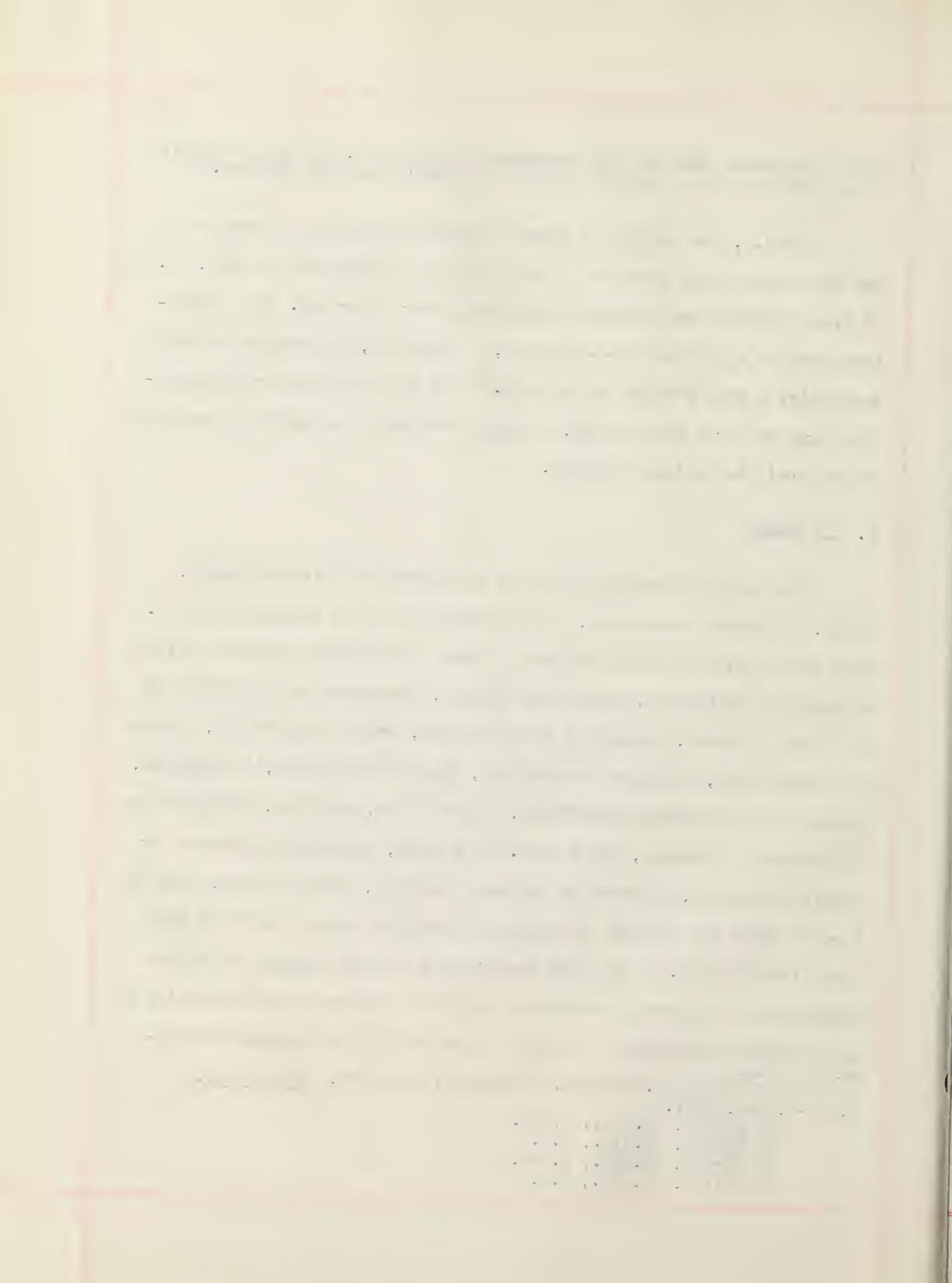
12 Patrick S. Madigan, "Military Psychiatry," Psychiatry, 4:225-6, May, 1941.

13 Porter, op.cit., p.364.

14 Miller, op.cit., p.5.

15 Farago, op.cit., p. 54.

16 Miller, op.cit., p.8.



gression. Rapidly trained volunteers and men over forty, especially married ones, are hit the hardest.¹⁷ Now that men over forty, most of them married, are soon to be inducted into the Army, and now that the training periods are being shortened, the above statement takes on real significance.

Psychological warfare is now waged by all nations. Fear is used as an instrument in this new type of warfare. The Germans were the first to use protracted bombardment by aerial artillery and tank-cannon not primarily for the purpose of material destruction but rather for the rapid disintegration of enemy morale through the accoustic effects of screaming Stukas and siren-attached bombs and the tremendous, terrorizing impact of mass bombardment. The first effect on enemy soldiers, it was found, is a marked lessening of will-power rapidly developing into nerve paralysis and acute fear neuroses.¹⁸

A brief discussion of the dynamics of mental and nervous breakdown in war may prove illuminating. Flight and attack are normal reactions to danger and need, on the animal level, i.e. biological adaytation to the instinctual drives. In man, the social inheritance, especially the moral consciousness, perpetually inhibits these drives. The instincts of the front line soldier demand flight or attack. Military discipline forbids the first and limits the second. Where the ego controls are inadequate to handle the resulting conflict, breakdown may occur.¹⁹ In the war neuroses we have conditions of life which place an immediate and overwhelming strain upon the instinctual endowments of man.²⁰ The more

17 Ibid., p.13.

18 Farago, op.cit., p.56.

19 Miller, op.cit., p.109.

20 Ibid., p.108.

severe is the present strain, the less significant will the antecedent background have to be to induce an actual breakdown.²¹ Many cases of wartime neurosis, especially early breakdowns, were found, on careful analysis, to be tied to long-standing feelings of insecurity. Sheltered men, when their friends or respected officers were removed, broke down.²² Severe and prolonged stress may cause a breakdown in anyone.²³ It is thus quite clear that the chances that neuropsychiatrically disabled soldiers can survive a modern war unhurt are pretty slim.

II CONSEQUENCES OF INDUCTING MARTIAL MISFITS

A. TO INDIVIDUALS CONCERNED AND TO THEIR COMMUNITIES

There is no need to prove at length that feeble-minded soldiers are out of place in a highly mechanized and collectivized modern Army. Men with frank psychoses similarly don't belong there, and rarely do they slip by selective service medical or psychiatric examiners. The chief problems are caused by several types of misfits who are not so readily detectable, hence who enter the service in large numbers.

The more common of these are the psychopaths, the neurotics, and the cyclothymics. Psychopathy has been defined as "chronic and persistent social maladjustment, emotional immaturity, desire for immediate satisfactions without regard to the future, impulsiveness, egoism, poor judgment, inability to conform to social or ethical standards, and inability to adjust to, or profit by, experience."²⁴ George Partridge in 1930 classified psychopaths into three groups: 1. the inadequates: the

21 Ibid., p.106.

22 Ibid., p.115.

23 Miller, op.cit., p.6.

24 William H. Dunn, "The Psychopath in the Armed Forces," Psychiatry, 4:252, May, 1941.



insecure, depressive, weak-willed, and asthenic types; 2. the emotionally unstable and egocentric: the contentious, paranoid, explosive, excitable, and aggressive types; 3. the most flagrantly anti-social: the liar, swindler, vagabond, and sexual deviate.²⁵

Psychoneurosis divides itself into three main types: hysterias, morbid anxieties, and obsessions. The latter is subdivided into hypochondriasis, phobias, and compulsive behavior.

The cyclothymic is characterized by major mood swings that are not obviously related to events.²⁶

These types, as a rule, are unable to stand the strains of war. The neurotic soldier often breaks out with overt neurotic behavior as a "flight into illness" in an attempt to escape the front lines. With malingerers this is a conscious process; with neurotics, it is unconscious.²⁷ The most common neurotic symptoms, sometimes called psychosomatic disorders, are the gastrointestinal and cardiovascular disorders, and hyperthyroidism. The incidence of the latter in the last war was disproportionately large.²⁸ The chief cardiovascular disorder was alternately called soldier's heart, D.A.H. (Disturbed Action of the Heart), or effort syndrome. This functional heart disorder was very common in the last war. Then there was the gas neurosis which bore a similar relation to the lungs as did effort syndrome to the heart. i.e. it had predominantly respiratory symptoms.²⁹

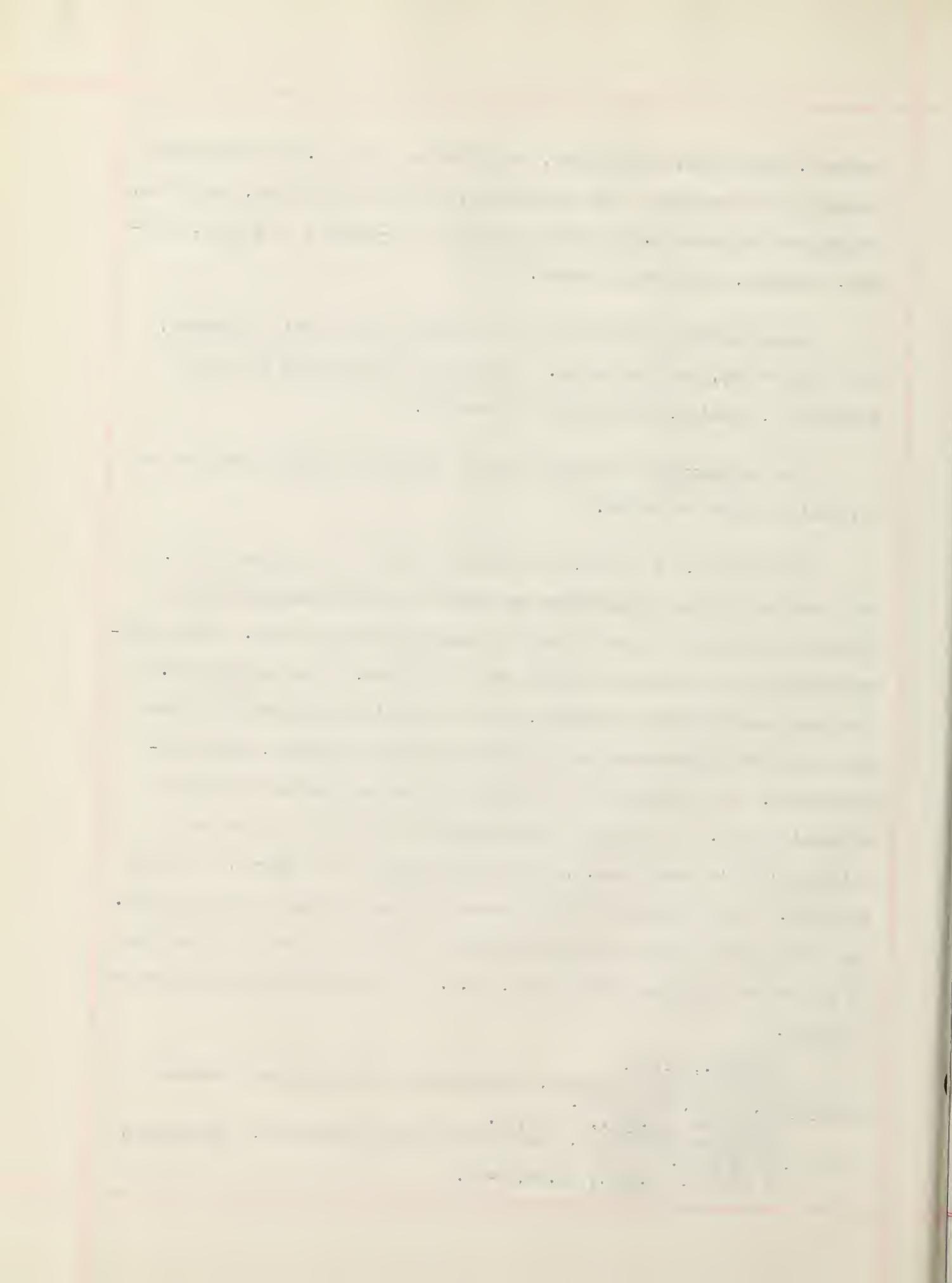
25 Ibid., p.253.

26 Harry Stack Sullivan, "Psychiatry and the National Defense," Psychiatry, 4:214, May, 1941.

27 Miller, op.cit., pp.11,12.

28 Lauren Howe Smith, "Selective Service Psychiatry," Psychiatry, 4:246-7, May, 1941.

29 Miller, op.cit., pp.18,20-21.



The story of an actual case of mental breakdown in the last war will vividly reveal the effects of war on unfit soldiers. After the war one such casualty was persuaded to write his life history. After describing his fears and misfortunes from childhood onward, including some hysterical illnesses, he gave this vivid and brief account of his army career:

All at once I was called to the colors; my spirits go down but I try to overcome this feeling and face it out, but every day that fear begins again to get hold of me, these thoughts of the past get their grip both morally and domestic until I get amongst the shells. I lose my sleep and go off my meat and then here I am putting my horses in the water tank: a shell bursts with a terrible crash, my horse plunges and gallops away from me. I seem to be rooted to the ground trembling from head to foot, the fragments all landing around me. After that, no matter what sound I heard I am ducking, expecting to be blown to pieces every minute, and I begin to get so confused and stupid it ends with major and quarter-master taking me up before the doctor. The next I am sent off to the clearing station.³⁰

This man's condition was not something born of the war; he obviously had been a candidate for a mental hospital at the time he enlisted.³¹ Such a man should never have been accepted into the Army, for it is well known that the existence of neurotic symptoms in civil life predisposes to their reappearance in increased and altered form in war.³² To take such a man and have him break down early in his military career is a pity, for many persons destined to fail if militarized under the conditions that obtain in a modern Army frequently do nicely in civil life.³³ This fact has been recognized by other nations, too. The Germans and Poles³⁴ urged the elimination of all psychopaths from the armed forces.

One of the reasons why so many vocationally unfit soldiers enter the Army is the shortsightedness of many selective service local boards.

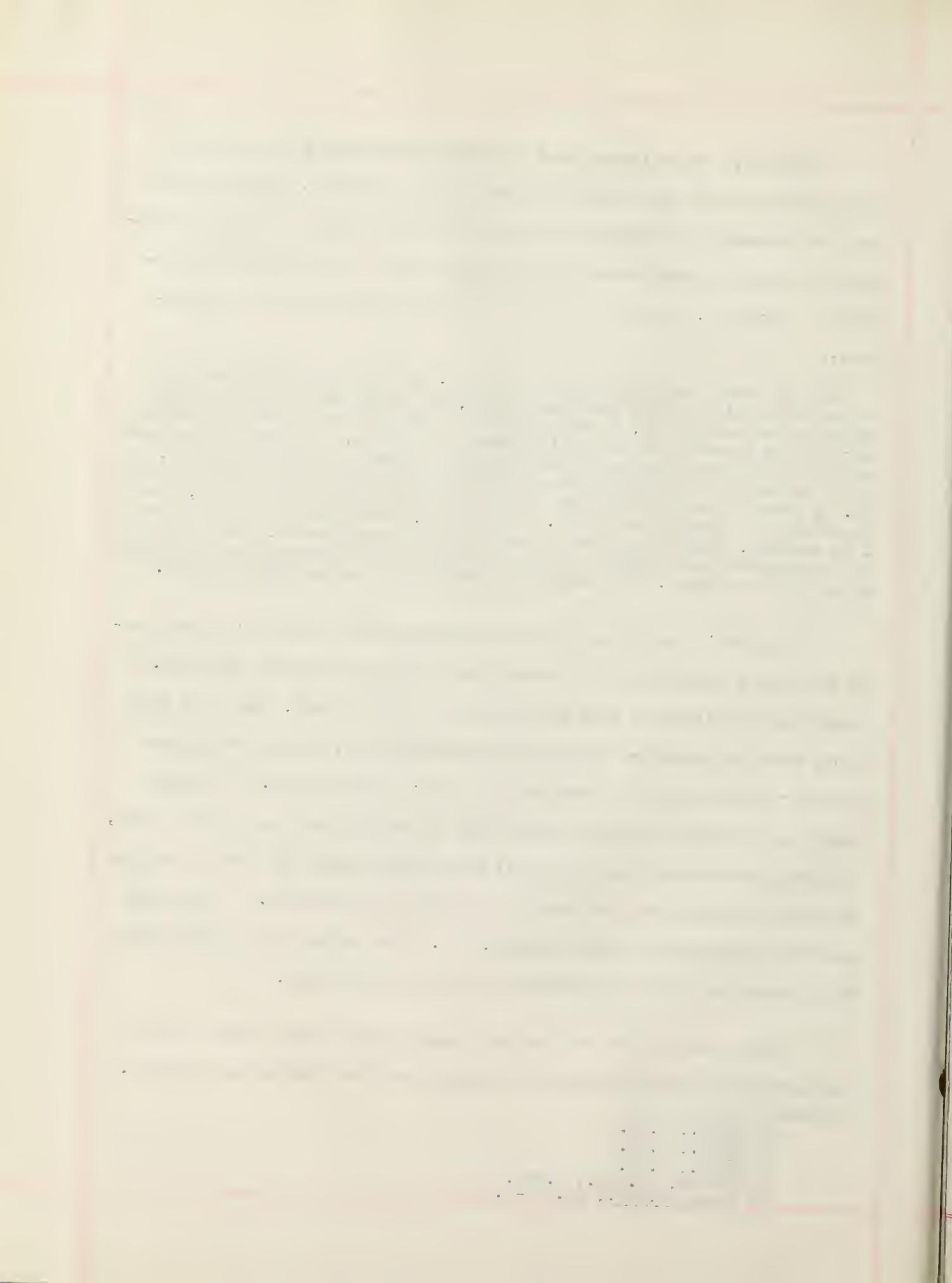
³⁰ Ibid., p.36.

³¹ Ibid., p.36.

³² Ibid., p.10.

³³ Porter, op.cit., p.371.

³⁴ Dunn, op.cit., pp.254-5.



Many of them are today repeating the mistake commonly made during the last war of swooping all the "ne'er-do-wells" into the Army on the theory that it would "make men out of them."³⁵ Sometimes the ire of local board examiners is aroused by malingeringers whom they try indignantly to force into the Army.³⁶ This is a more excusable but no less grievous error. One authority answers this question with forceful lucidity:

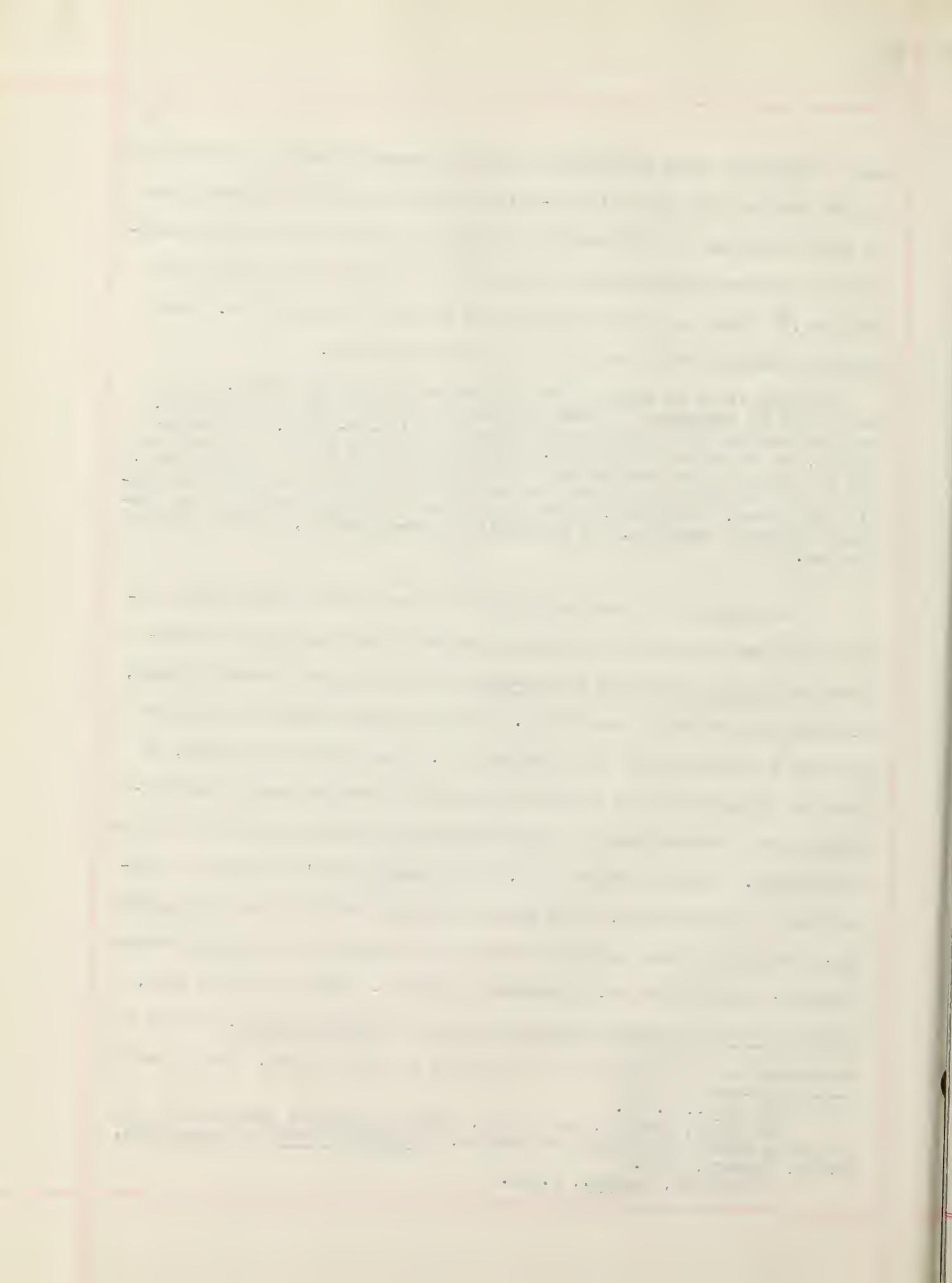
The Army is in no sense a social service or curative agency. It is neither to be considered a haven of rest for the wanderer or shiftless, or a corrective school for the misfits, the ne'er-do-wells, the feeble-minded, or the chronic offenders. Furthermore it is neither a gymnasium for the training and development of the undernourished or underdeveloped; nor is it a psychiatric clinic for the proper adjustment to adult emotional development. Therefore, there is no place within the Army for the physical or mental weakling, the potential or pre-psychotic, or the behavior problem.³⁷

What happens to these casualties? "Line of duty" regulations provide that men breaking down within six months after induction in peace-time and within ninety days in war-time with a functional mental illness, are sent back to their communities. Thus men formerly able to function must now be supported by their communities. Only after that period, or when the breakdown is due to toxic or traumatic factors clearly attributable to the service does the federal government assume responsibility for the patient. With the former type, if the patient isn't a danger to himself or to his community, he is returned to his family if they will accept him; else to his state hospital if the state authority will accept responsibility; otherwise to St. Elizabeth's Hospital. With the latter type, where no record of mental abnormality prior to service exists, the man is considered to have acquired his disability in line of duty. Such a man is

35 Ibid., p.253.

36 Kiene, Hassell, and Miller, "Neuropsychiatric Examinations at the Rhode Island Army Induction Station," American Journal of Psychiatry, 98:514, January, 1942.

37 Madigan, op.cit., p.229.



honorable discharge with a "C.D.D.," (certificate of disability and discharge), to his own care if possible, to his family's care if necessary, or to the Veterans' Administration, which provides a bed for him.³⁸

Since it is now commonly recognized that "potential breakdowns break down early,"³⁹ the probability that most of these misfits swept into the Army will survive the first ninety days of service unscathed is not too great. Thus the buck passed to the Army by the local boards frequently becomes a boomerang.

B. TO MILITARY EFFICIENCY AND MORALE

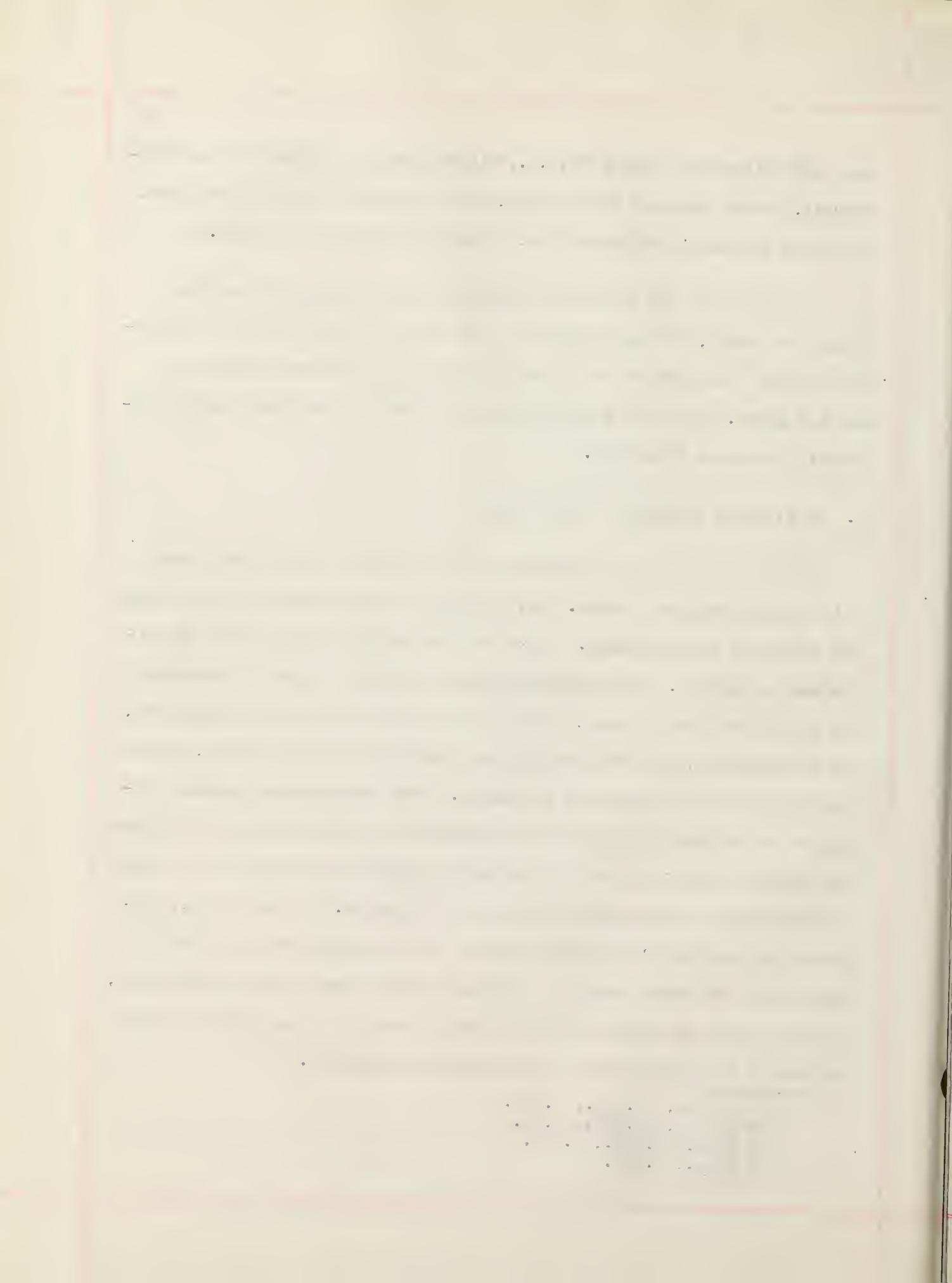
Not all potential neuropsychiatric casualties break down during this initial training period. All too many of them reach the front lines and engage in active combat. These men frequently affect morale and efficiency adversely. The psychopaths are a constant source of annoyance and trouble to the officers, forming the larger number of the absentees, the discontented, the inefficient, the inmates of the guardhouse, and the frequenters of the regimental infirmary. They constitute a greater menace to the military organization by lowering the efficiency and impairing the general morale than do the obviously diseased types which are readily recognized and without great difficulty eliminated.⁴⁰ One writer,⁴¹ reporting on two European studies, states that seventy-three per cent of a small group of German deserters studied psychiatrically were psychopaths, and that forty per cent of the military prisoners in the punishment battalions of the Russian Army were likewise psychopaths.

³⁸ Porter, op.cit., p.568.

³⁹ Miller, op.cit., p.36.

⁴⁰ Dunn, op.cit., p.254.

⁴¹ Ibid., p.255.



Of the three types of psychopaths listed above,⁴² the inadequates are the least troublesome. Still the depressives among them frequently do-sert or attempt suicide; and the asthenics can't stand soldiering because they are emotionally weak, overly sensitive, tender, hence fail physically, become hypochondriacal, and simulate illness. But the emotionally unstable and egocentric, and the flagrantly anti-social are a real menace to morale and efficiency. They are undependable because they are capricious and impulsive. The aggressive psychopaths may win medals for heroism, but they can't take retreat or inactivity. These emotionally unstable types may spread panic among whole detachments. They thus often serve a useful purpose in promoting the state of psychic tension which the enemy now tries to produce. In this they may be almost as effective as enemy agents.⁴³

A bulletin of the Surgeon General's Office in the last war, concerned about psychopaths as a whole, noted that they are considered useless in the Army as they are unable to adjust to discipline. They are persistently insubordinate; excessive in the use of, and intolerant to, alcohol; likely to be addicted to sexual perversions. When they can't escape conditions to which they cannot adjust, they may develop a psychosis.⁴⁴ When these or any other types break down mentally, the men make allowances for them; as a result of this discrimination, morale and discipline suffer.⁴⁵

⁴² Cf. p.8.

⁴³ Dunn, op.cit., pp.256-7.

⁴⁴ Ibid., p.254.

⁴⁵ Porter, op.cit., p.65.



III STATISTICAL EVIDENCE FROM THE LAST WAR

After the last war, numerous studies were made of the incidence of neuropsychiatric breakdown in the war, hospital admissions, types of breakdown, rates of discharge, and costs to the Federal government of hospitalization, treatment, and maintenance of these casualties. A brief review of some of the facts should be illuminating.

The rate of neuropsychiatric breakdown in the last war was high. Even before we entered the war, in 1916, ten per cent of our regular Army discharges were for neuropsychiatric reasons. This is three times as great as the rate of hospital admissions of adults in New York State for the same illnesses.⁴⁶ From April 1, 1917 to December 31, 1919, nearly a hundred thousand American soldiers were admitted to hospitals for neuropsychiatric diseases. The chief types of illness are shown in the following table:⁴⁷

TABLE I
NEUROPSYCHIATRIC HOSPITAL ADMISSIONS IN THE AMERICAN ARMY,
APRIL 1, 1917 TO DECEMBER 31, 1919

Type of Illness	Number
Mental deficiency	13,063
Epilepsy	8,781
Neurasthenia	8,028
Psychoneuroses	7,561
Dementia praecox	6,549
Hysteria	6,390
Other types of psychoses	5,652
Constitutional psychopathic states	5,146
Neurocirculatory asthenia	4,510
Other disorders	32,887
Total	97,657

46 von Storch, et al., "Observations and Suggestions Concerning Neuropsychiatric Examinations for the Army of the U.S.," N.E. Journal of Medicine, 224:890, May 22, 1941.

47 Madigan, op.cit., p.227.



In 1921, of the 160,000 pensions paid to members of the A.E.F., 65,000 or thirty-six per cent were for neuropsychiatric disabilities.⁴⁸ Thousands of our own troops were returned to civilian life during the war as neuropsychiatric casualties. Seventy-two thousand such troops were returned up until May 1, 1919.⁴⁹ Over three thousand were returned from overseas shortly after their arrival in France. Prior to June 30, 1919, the following cases were returned from overseas:⁵⁰

TABLE II

A.E.F. NEUROPSYCHIATRIC CASUALTIES RETURNED PRIOR TO JUNE 30, 1919

Type of Casualty	Number
Psychoses	3,897
Constitutional psychopathic states	504
Epilepsy	416
Mental deficiency	762
Psychoneuroses	2,888
Alcoholism	51
Drug addiction	6
Recovered	95
Total	6,319

50 Madigan, op.cit., p.227.

By 1927 nearly fifty per cent of all patients getting hospitalization treatment under the Veterans' Bureau were neuropsychiatric cases. By the beginning of 1941, it was estimated each such case had cost about \$30,000.⁵¹

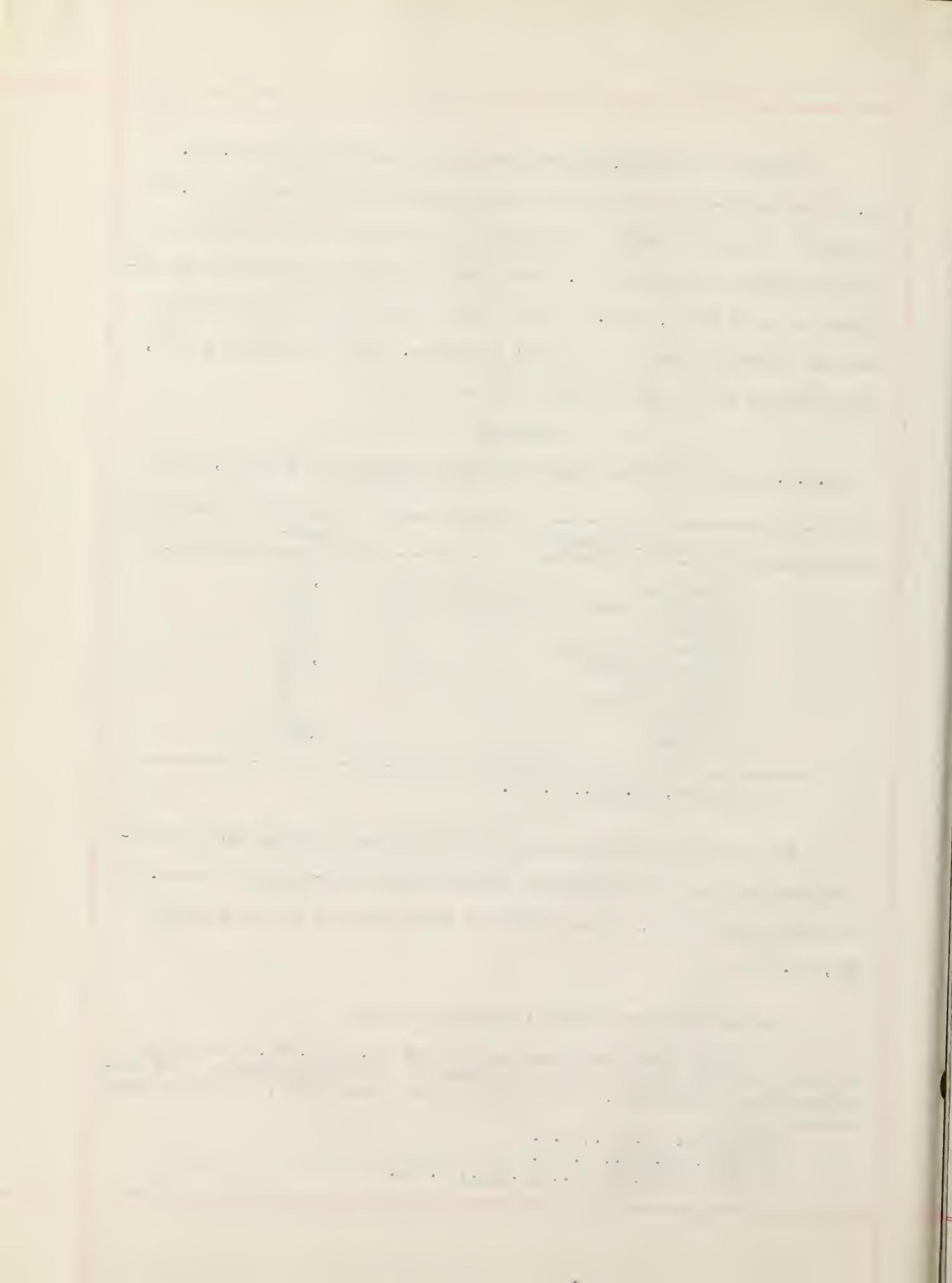
One authority on veterans' problems writes:

During the fiscal year ending June 30, 1940, 68,727 veterans collected nearly forty-two million dollars as disability awards. For permanent, total disability, \$100 monthly is the usual award, but for certain

48 Miller, op.cit., p.8.

49 Dunn, op.cit., p.263.

51 von Storch, et al., op.cit., p.891.



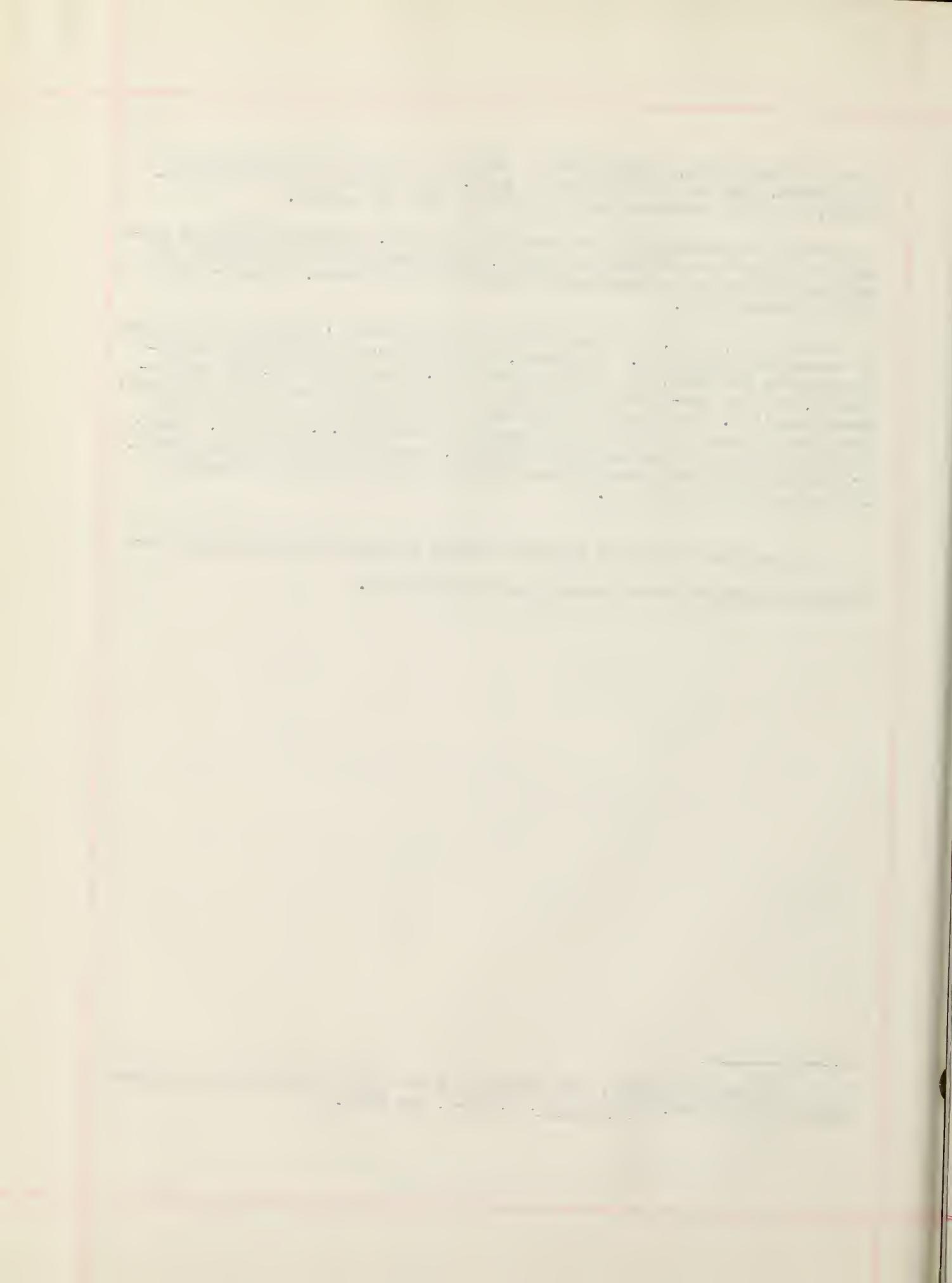
types of disability, such as being helpless or in need of regular aid or attendance, also to \$15 monthly is paid. In addition to disability awards, hospital treatment and domiciliary care are costly.

During the seventeen years from 1923 to 1940, nearly 612 million dollars were spent for disability awards, and from 1926 to 1940 nearly 200 million dollars on hospitalization and domiciliary care. Total - nearly 925 million dollars.

On June 30, 1940, 80 "facilities" of the Veterans' Administration were in operation in the U.S. Of these, 27 (30%) were hospitals for neuro-psychiatric patients, especially psychotics. There were 32,016 such patients, or over one-half of the total hospital population of the Veterans' Administration. The hospital turnover of such patients is much slower than that of general medical and surgical, or even T.B. patients. Their hospitalization is indefinitely prolonged, hence they "freeze" many beds. Proper selection of potential breakdowns is the only way to alleviate this situation in this war.⁵²

A billion dollars is a pretty strong argument for eliminating potential neuropsychiatric casualties from the Army.

⁵² Martin Cocley, "The Economic Consequences of Inadequate Psychiatric Examinations," Psychiatry, 4:262-3, May 1941.



CHAPTER III

ATTEMPTS AT ELIMINATING MENTAL MISFITS BEFORE INDUCTION

That there was some recognition of the importance of eliminating potential mental and nervous casualties in the last war is evidenced by the existence then of a psychiatric examination as a part of the selective service system. It might be profitable to review briefly the philosophy, structure, and function of that examination system and to contrast it with that of our present selective service system in this war. This juxtaposition, it is to be hoped, will reveal the extent of progress, if any, made in this vital field in the past quarter century.

I THE SELECTIVE SERVICE NEUROPSYCHIATRIC EXAMINATION SYSTEM IN THE LAST WAR

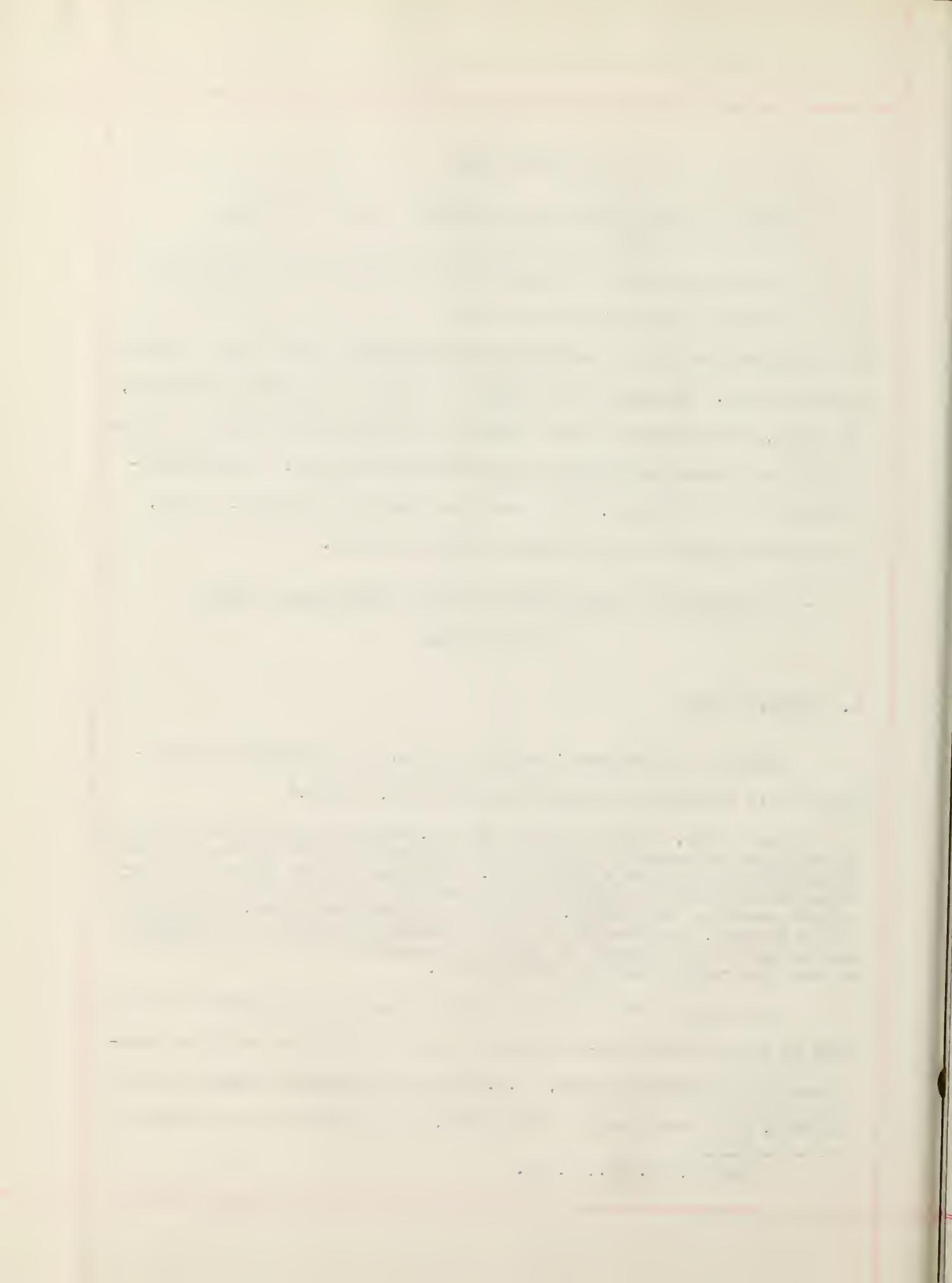
A. THE LATE START

Cooley of the Veterans' Administration, in discussing the neuro-psychiatric examination system in the last war, writes:¹

In April 1917, when we entered the war, medical reports were available of the high incidence of disorders of the nervous system in the European armies fighting two and a half years. Hence any failure by us to appreciate the necessity of excluding draftees with patent or suspected latent defects would be inexcusable. The necessity was recognized, but due to faulty methods, attributable in part at least to questions of authority and in part to the demands of haste in dispatching troops to the theatre of war, the results were not satisfactory.

Only late in the war was it realized that the elimination from the Army of those "whose make-up was such that their behavior would be inconsistent with military service," i.e. those with manifest psychoses and neuroses, and those likely to break down, was in the interests of both

¹ Cooley, op.cit., p.262.



individual and country. Osler wrote in 1917, "I feel confident that careful weeding out of the mentally unstable will certainly greatly reduce the number of shell-shock cases that are bound to appear in our casualty lists."²

General Pershing accelerated the awakening process when he cabled home on July 15, 1918, "Prevalence of mental disorders in replacement troops recently received suggests urgent importance of intensive efforts in eliminating mentally unfit prior to departure from the U.S."³ When the Office of the Surgeon General received this cable, it studied the situation and learned that in divisions sent abroad after a supposed examination of their personnel, there were 3,005 men disabled by such gross and easily detectable defects as tabes dorsalis, dementia paralytica, epilepsy, psychoses, psychoneuroses, and even imbecility.⁴ As a result of this and similar studies, psychiatric standards applied to selection of personnel increased greatly in vigor between the first and second million men sent to camp.⁵

B. NATURE OF THE EXAMINATION SYSTEM

At first only those soldiers who were referred by medical officers and company commanders were examined, but this system proved inadequate. Then a hasty examination of all men was inaugurated. It consisted of a brief conversation with and observation of each man during his physical examination. From a hundred to a hundred fifty cases a day were thus handled with reasonable accuracy. Recommendations were considered by a dis-

² Miller, op.cit., pp.22-3.

³ Ibid., p.168.

⁴ Cooley, op.cit., p.262.

⁵ Sullivan, Mental Hygiene, op.cit., p.9.



ability board composed of general medical officers and psychiatrists. It was found that nine officers cooperated more than medical officers, possibly because the former rated men according to their "conduct, behavior, and efficiency."

In these examinations, about ten per thousand men examined were found unfit for service on account of the following neuropsychiatric disorders:⁶

TABLE III
CAUSES OF NEUROPSYCHIATRIC REJECTIONS IN THE LAST WAR

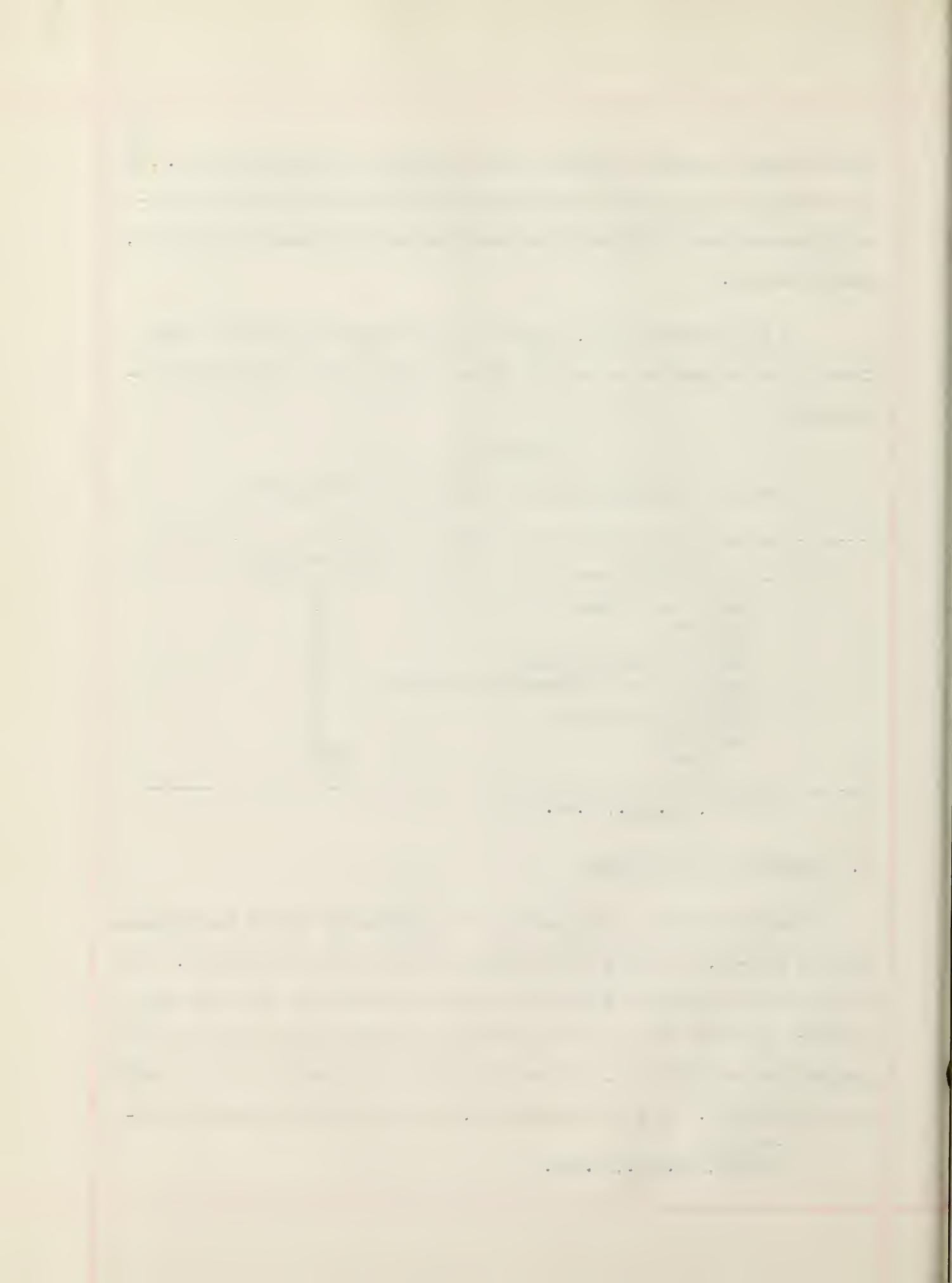
Disability	Rate per Cent
Mental deficiency	31
Nervoses	17
Psychoses	11
Organic nervous disease	10
Constitutional psychopathic states	9
Epilepsy	9
Endocrine disorders	7
Inebriety	6
Total	100

6 Miller, *op.cit.*, p.34.

C. EXAMINATIONS IN THE SYSTEM

Not all draftees were examined by psychiatrists before their induction in 1917-18, but the large majority were given some examination. That these examinations were inadequate is made evident by the fact that many soldiers who broke down soon after reaching camp had shown characteristic symptoms before induction, and that the majority of them had "significant" family histories.⁷ The rejection of 72,000 men for neuropsychiatric dis-

7 Cooley, *op.cit.*, p.261.



abilities still allowed 3.5 per cent of all men in service to be discharged for this cause in the year and a half of service.⁸

In 1917-18 the 5 million men who were passed by local boards and admitted into the Army were later given special examinations. Two per cent of them (69,394) were found to have neuropsychiatric disorders. Ninety-six per cent of these were considered not to have arisen in line of duty. Data on fifty thousand of these men revealed that with eighty-five per cent of them the disorders had begun at least five years before they entered the Army.⁹ To make matters worse, many men who were recommended for rejection by neuropsychiatric officers were taken into the Army. The official history of the "Medical Department on the World War - Vol. X, 1929" reported, as quoted by Cooley,¹⁰ that 8,640 such men were inducted into the Army despite the fact that mental and nervous diseases were discovered in them in the U.S.

Finally, the recent consultants to the National Selective Service System, Harry Stack Sullivan, states that a neuropsychiatric examination at conscription in the last war could have reduced our billion dollar cost to date by about fifteen per cent.¹¹

II THE CHANGES IN NEUROPSYCHIATRIC THINKING SINCE THE LAST WAR

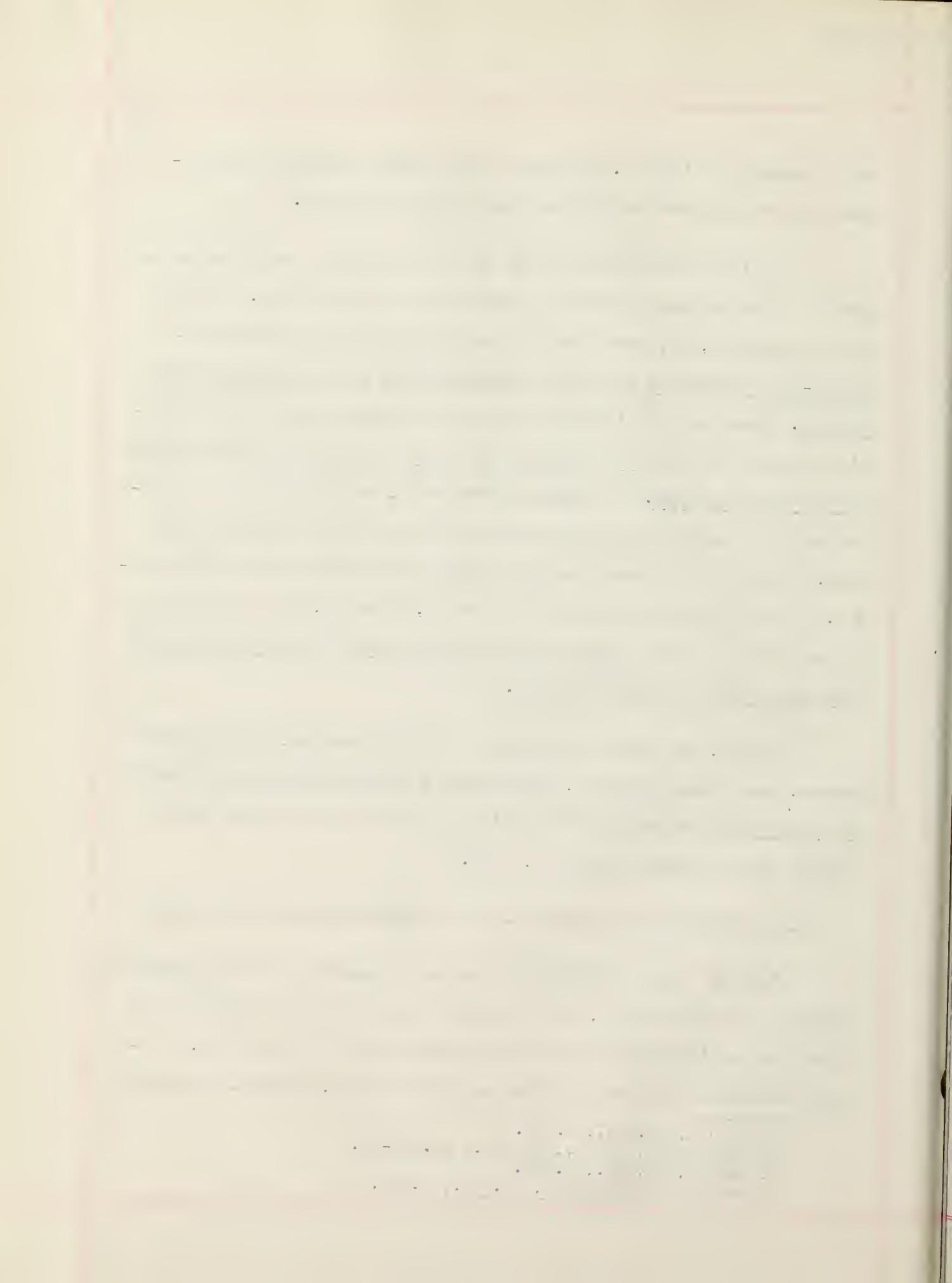
This war finds a fundamental change of emphasis in neuropsychiatric thinking induced, in part, by the general progress in the field as well as by the costly lessons learned from experience in the last war. Perhaps the most direct and immediate causative factor, however, has been

⁸ Porter, op.cit., p.365.

⁹ von Storch, et al., op.cit., pp.890-91.

¹⁰ Cooley, op.cit., p.262.

¹¹ Sullivan, Psychiatry, op.cit., p.205.



the altered type of warfare facing us today and the new conditions under which it is waged, compelling a drastic revision in qualifications and standards for military service.

What are these new conditions of warfare, and what changes have they compelled?

A. NEW CONDITIONS OF WARFARE

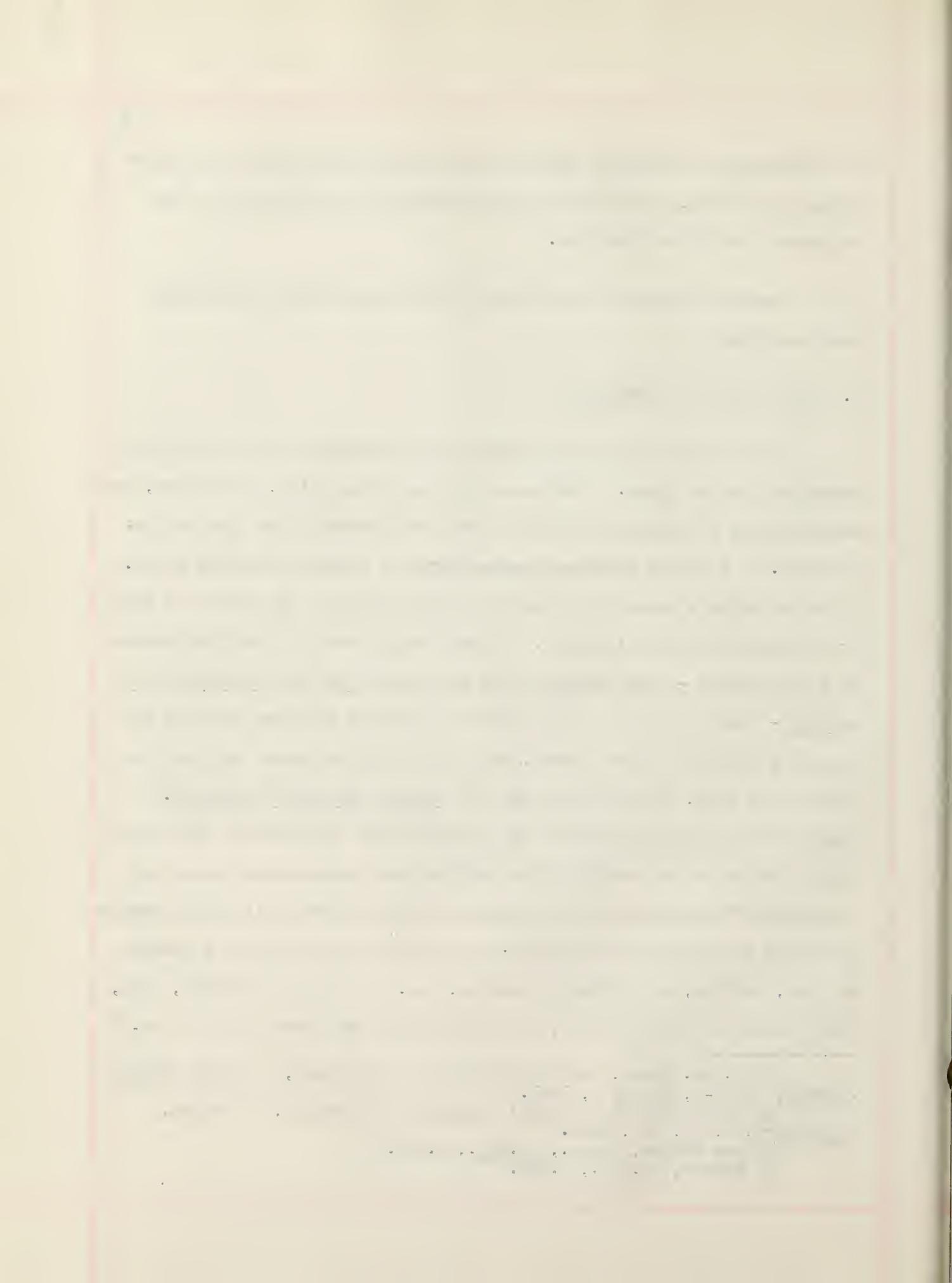
It is today a truism that modern war is chiefly characterized by mechanization and speed. This means that speed in action, initiative, and understanding of technical apparatus are more necessary now than in former wars.¹² A modern highly-mechanized Army is a highly selected group. It is no longer a place for a man with a good body but not much of a brain or not much emotional stability. If we think of really selective service in total defense - that men are to be used where they can best help the country - then everyone should be able to see that many men can best be used in industry or other places, and only a limited number can best be used in the Army, and those are men with special military aptitudes.¹³ Some of these special aptitudes are emotional and intellectual stability; good coordination so essential for carrying out synchronized mechanical operations;¹⁴ the capacity to get along and to cooperate with other people in highly cooperative undertakings; the ability to withstand the ravages of fear, fatigue, and military reverses, etc. It is quite obvious, then, that stability, dependability, and intelligence are needed in this war.¹⁵

12 F.J.S. Esther, "Mental Defectives in the Army," British Medical Journal, 2:454-5, August 9, 1941.

13 "A Seminar on Practical Psychiatric Diagnosis," Excerpts, Psychiatry, 4:284, May, 1941.

14 von Storch, et al., op.cit., p.591.

15 Porter, op.cit., p.371.



This means that mental defectives, for example, should definitely be ruled out this time. Hence, it is found that when the Army in this war originally set up a Mental Age of eight years as the critical level, psychometrists objected and insisted upon raising it to twelve years.¹⁶ A British authority¹⁷ would reject all men with a Mental Age of ten years or less.

An eminent American psychiatrist¹⁸ points out that not only have the strains of modern warfare increased, but the stability of American youth has diminished. Hence, he concludes that if in the last war 2 per cent of registrants were rejected on neuropsychiatric grounds by local boards and another $2\frac{1}{2}$ per cent by camp boards, this time we should have at least 8 per cent rejections.

B. NEW EMPHASIS IN NEUROPSYCHIATRIC THINKING

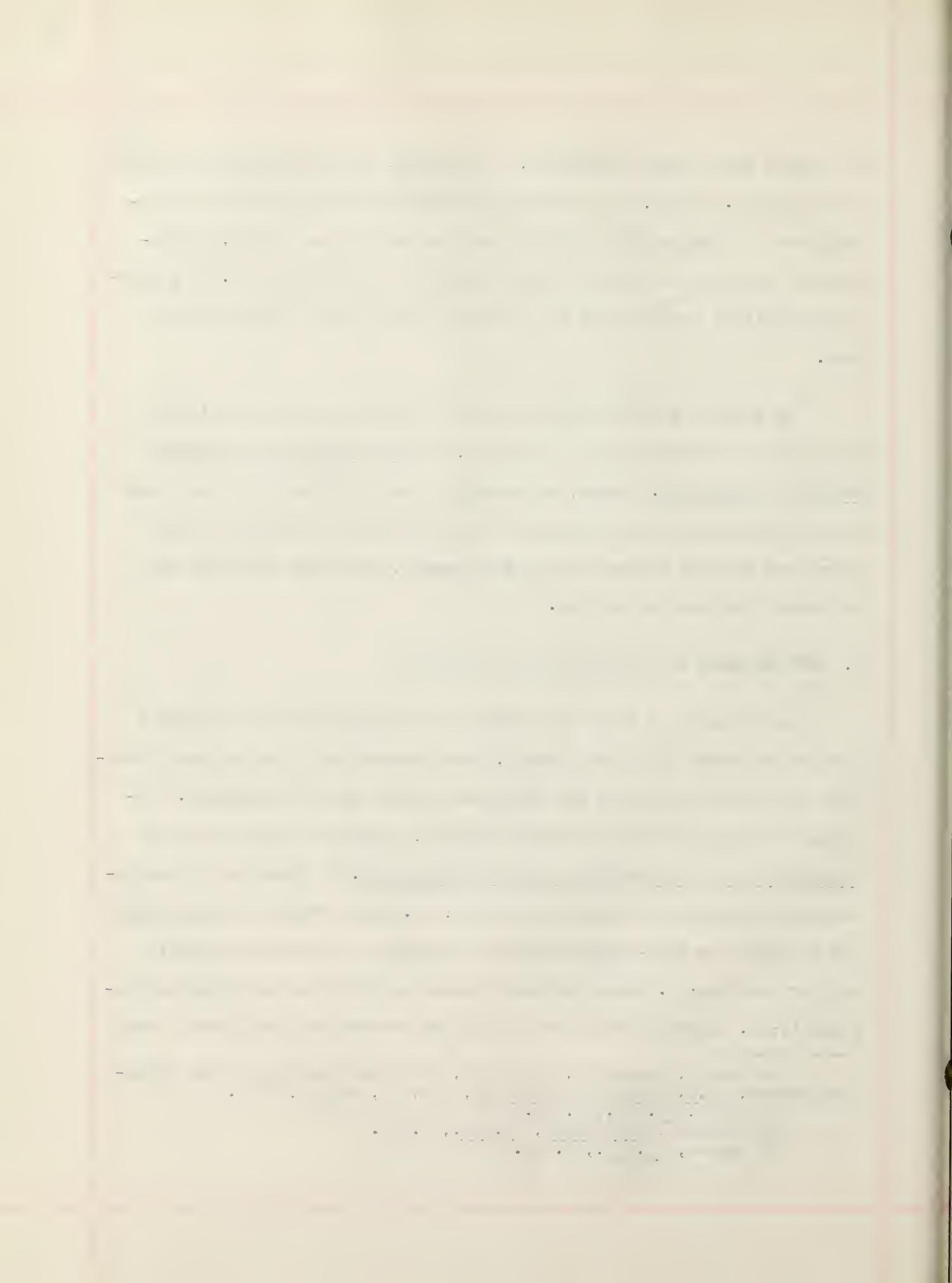
As a result of these new conditions of warfare and the different type of personnel which they demand, neuropsychiatric thinking about standards of military selection has undergone a basic shift in emphasis. Instead of trying to weed out martial misfits, emphasis is now placed on weeding in men vocationally suited for modern war.¹⁹ Vocationally unsuited men are now divided into three groups: 1. those whose civilian utility and capacity for self-support would be destroyed or greatly reduced by military service; 2. those who would become psychotic or seriously neurotic; 3. those who would do well in the service but would break down

16 Atwell, Bloomberg, and Ellis, "Psychometrics at an Army Induction Center," A.M. Journal of Medicine, 24:699, May 22, 1941.

17 Esner, op.cit., p.435.

18 Sullivan, Psychiatry, op.cit., p.204.

19 Porter, op.cit., p.564.



after demobilization due to their inability to readjust to civil life.²⁰

In addition, leading psychiatrists are giving considerable thought to the need of insuring the future usefulness in civil life of neuropsychiatric rejectees who carry back a stigma to their former communities. Various suggestions have been advanced to help rejectees overcome this serious handicap. Bowman²¹ recommends labelling these men rejected for "lack of military aptitude" or some such term. Sullivan²² urges a program of education for the public at large to apprise them of the fact that "we are not so much concerned with sorting out the unfit and the mentally disordered as with sorting in the people who are peculiarly fit for the military vocation."

Cooley²³ warns against inadequate examinations due to haste in mobilization, pointing out that our large reserve of manpower permitted a proper choice of selectees. Bowman²⁴ insists that "it is better to reject some people who might possibly be suitable for service, than to take a chance and induct many who will prove to be unsuitable." Sullivan²⁵ succinctly summarizes this new emphasis in these words: "In total war almost everyone has a place, but the only place for anyone is the place where he is most apt to continue to be efficient, reasonably comfortable, and a successful member of the American Commonwealth."

III SELECTIVE SERVICE NEUROPSYCHIATRIC EXAMINATION SYSTEM IN THIS WAR

In order to translate the above thinking into action, changes in

20 Sullivan, Psychiatry, op.cit., pp.205-6.

21 Seminar, op.cit., p.283.

22 Ibid., p.273.

23 Cooley, op.cit., p.261.

24 Seminar, op.cit., p.282.

25 Sullivan, Mental Hygiene, op.cit., p.14.



structure and function have been effected in the selective neuropsychiatric examination system. A somewhat detailed picture of the structure and function of this new system follows.

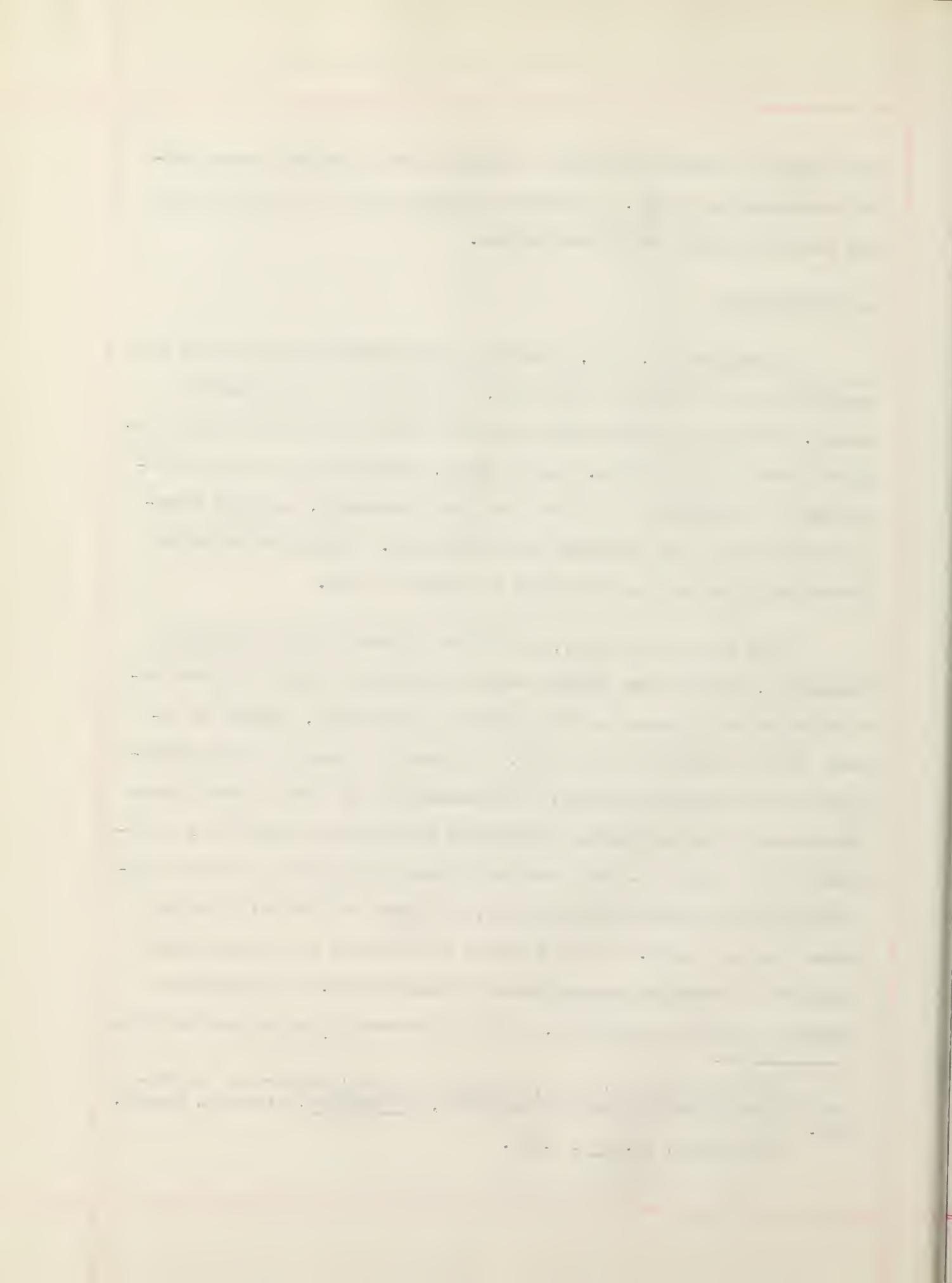
A. DEVELOPMENT

On September 16, 1940, after President Roosevelt had declared this country to be in a state of emergency, the Selective Service Law was passed. At once the Army began to put into action the detailed plan prepared several years earlier. Local boards, medical advisory boards consisting of specialists to advise local board examiners, and Army induction boards were soon organized and functioning. Slowly the Selective Service machinery slipped into gear and began to move.

While this was going on, the William Alanson White Psychiatric Foundation, aware of the immense responsibility that this Selective Service System would impose on the psychiatric profession, decided to devote all its energies to this task. It prepared a memorandum on psychiatry and the Selective Service. This memorandum was read before a group of national Selective Service authorities by Harry Stack Sullivan, president of the foundation. As a result of this, Sullivan was appointed consultant to the national Selective Service System and Medical Circular Number One was issued.²⁶ This circular was intended to aid local board examiners in detecting neuropsychiatric disabilities.²⁷ It defined a minimum psychiatric inspection, aimed at discovering any of the following

26 Harry Stack Sullivan, "Annual President's Report of the William Alanson White Psychiatric Foundation," Psychiatry, 4:passim, August, 1941.

27 Seminar, op.cit., p.265.



eight major categories of mental or personality difficulties:

- Mental deficiency
- Constitutional psychopathic states
- Mood disorders
- Psychoneuroses and psychosomatic conditions
- Schizoid and paranoid states
- Chronic alcoholism
- General paresis
- Neurologic conditions (epilepsy, post-traumatic syndromes, paralyses and muscular atrophies, post-encephalitic states, etc.)

FIGURE 1. MAJOR CATEGORIES OF NEUROPSYCHIATRIC DISABILITIES²⁸

If psychiatrists were to be of service in this system, they would first have to be instructed how to handle the special problems they would face in this work. First of all, they had to understand that they were here dealing not with their usual types of seriously ill patients but with a comparatively normal group of people. This required an adjustment of their techniques to the needs of this group. In addition, a unity of diagnostic viewpoints and practises was essential.²⁹

To meet these and other needs, the Selective Service System organized, in the Spring of 1941, a series of seminars for psychiatrists of medical advisory and induction boards. First they discussed the military vocation and conditions of military training to give psychiatrists the facts upon which to prognosticate the suitability of each registrant. Veterans of the World War conscription then reviewed their experience in the last war to suggest methods of improving techniques. This was followed by a discussion of practical steps by which the psychiatrist can rapidly diagnose mental health or its absence, and prognosticate the probable effect on doubtful registrants of a year's military training, demobilization,

28 Sullivan, Psychiatry, May, 1941, op.cit., p.213.

29 Ibid., p.206.



and the ten subsequent years in the Reserve.³⁰

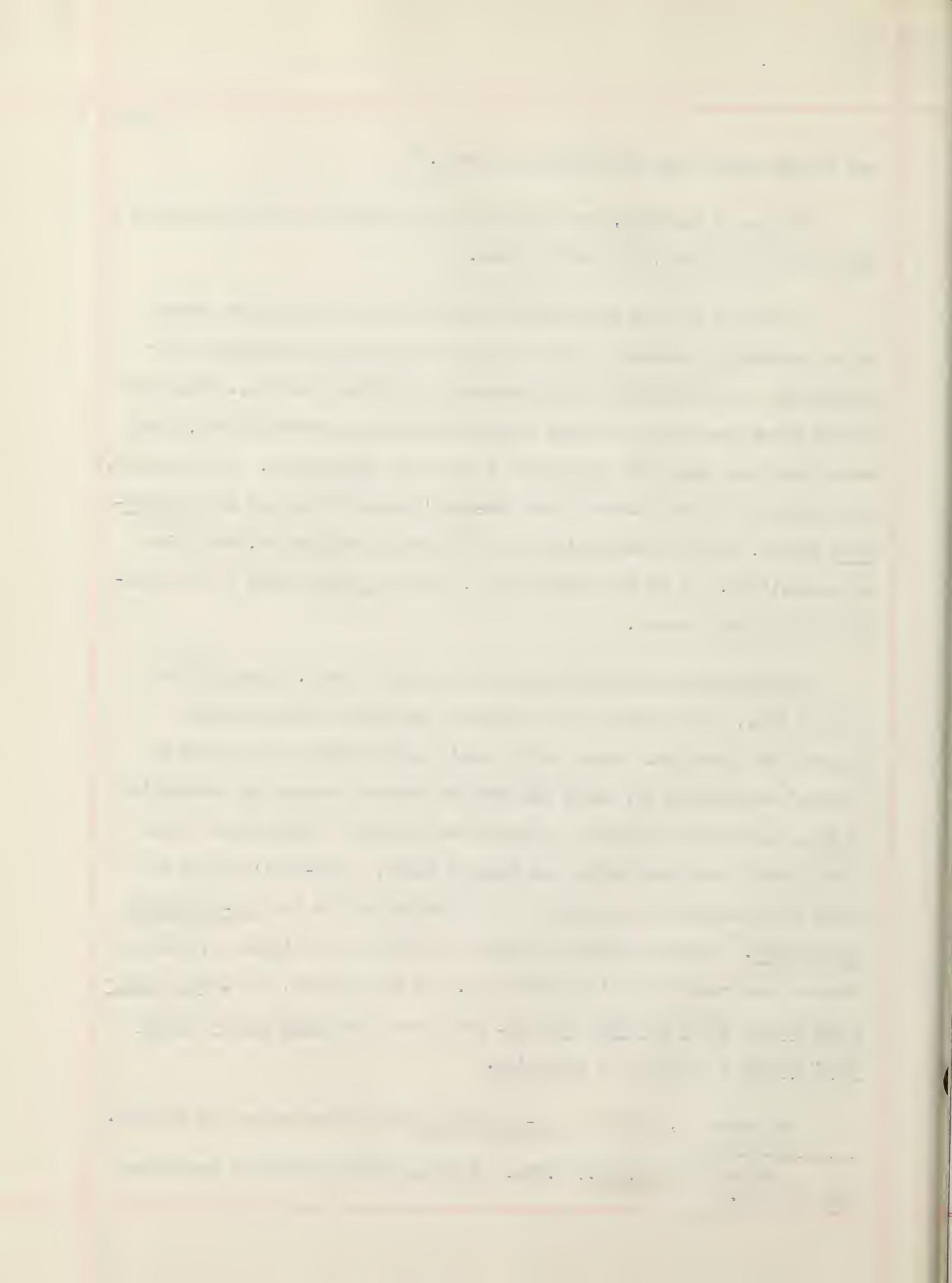
With this training, the psychiatrists returned to their respective home cities and towns, and went to work.

There has been an interesting development in the relative degree of responsibility assumed by local and by induction board examiners for passing on the suitability of registrants for military service. When the system first went into operation in Massachusetts in November 1940, local board examiners gave each registrant a complete examination. If he passed, he was classified as 1-A and given ten-days' notice to appear at an induction center, where he was again given a thorough examination, this time by specialists. If he was passed again, he was at once sworn in as a member of the armed forces.

This system continued in effect for about a year. Then, in the Fall of 1941, a new ruling of the National Selective Service System changed the situation. Henceforth, local board doctors were merely to "screen" registrants for gross and obvious defects through an examination or by a report of a reputable physician or hospital. Registrants could appeal their decisions before the Appeals Board. Five-days' notice was given to registrants to appear at an induction station for pre-induction examination. The registrants returned home and were notified several days later of the result of this examination. If they passed, then, when their local boards got a new call for men, they were given from ten to thirty days' notice to appear for induction.

On March 16, 1942 the pre-induction examination system was revoked.

³⁰ Seminar, op.cit., p.265. This was written prior to our entry into the war.



Under this latest scheme, local board doctors "screened" registrants, gave them a blood test, then, on the basis of their findings, classified those men as 4-F or 1-B if defective, or as 1-A if not. Now no appeal could be made of this decision. When the next call for men comes, the local board gives registrants ten days' notice to appear for induction. At the induction center a thorough examination is given, physical as well as neuro-psychiatric, and, if passed, the registrant is sworn in at once and shipped to a reception center. To make it easier for those registrants for whom this leaving of their occupations so abruptly, causes great hardship, local boards may, at their discretion, recommend to the Army Induction Board that these men be granted furloughs of up to ten days.

In addition, men rejected for remediable defects were asked to have these defects remedied at Army expense so that they could then be accepted into the Army. This was optional, not compulsory.³¹

In an interview with a second person,³² investigator learned some of the reasons for the change to this "single examination system." Four such reasons were given: 1. Elimination of duplication; 2. removal of undue hardship caused to men who, passed by their local board examiners and expecting to be inducted shortly, liquidated their affairs and then were rejected by induction board examiners; 3. rejection by induction boards of men passed as healthy by local board examiners was often considered to be a discredit to the latter; 4. small town doctors sometimes found it difficult to reject men for other than obvious defects, for such a decision was frequently most unpopular in the town.

31 Interview with chief clerk at Local Board 26 in Boston.

32 Lt.-Colonel Donald Currier, Chief Medical Examiner, State Selective Service System.



B. CURRENT ORGANIZATIONAL STRUCTURE

There are three channels of admission into the Army: by voluntary enlistment, by induction of National Guardsmen, and via selective service. The first group, except for air force candidates, get no neuropsychiatric examination; with the second group it is not routine; but with the third group it is.³³ Since this study deals with temporary rejectees in the Massachusetts Induction Centers, a review of the organizational set-up of the Massachusetts Selective Service System would be in order.

There are 173 local boards in Massachusetts. The medical examiners on these boards offer their services gratuitously. Rarely are there any specialists on these boards; they are mainly general practitioners. One to five examiners serve on each board. They may call on social agencies for investigations, and may use the medical advisory boards for consultation in doubtful cases. There is approximately one medical advisory board for every ten local boards throughout the country. In Massachusetts there are fifteen such boards. They are made up of outstanding specialists in the community. They use laboratory techniques when indicated (electro-encephalography, lumbar puncture, etc.)

There are three induction boards for Massachusetts: in Boston, Springfield, and Providence, R. I. The Boston board is active since November 11, 1940. It is composed of a medical director from the Army Medical Corps, and his civilian and military assistants. In March 1941 these consisted of a clinical pathologist, an oral surgeon, an otolaryngologist, an ophthalmologist, an orthopedic surgeon, a general surgeon, a psycho-

³³ von Storch, et al., op.cit., p.891.

metrist, three internists, and five neuropsychiatrists.

At first 100 men were examined daily. In February of 1941, this rose to 250 men. Final decision as to rejection rests, not with the specialists, but with the Army Medical Officer in charge of the induction board. Twenty-seven neuropsychiatrists have been employed on this board for from one to three days each week. During February 1941, five were on duty each day. Each examined fifty candidates a day, on the average. They worked five hours a day, hence devoted an average of six minutes to each candidate. This ranged from three minutes for normal men to ten or fifteen minutes for doubtful cases.³⁴

When men are passed by the Army Induction Board examiners, they are sworn into the Army and sent to one of 25 reception centers where a further intensive study is made by competent psychiatric officers of their behavior under Army conditions. This provides a valuable check on the previous examination.³⁵

C. DIAGNOSTIC CRITERIA AND TECHNIQUES OF EXAMINATION

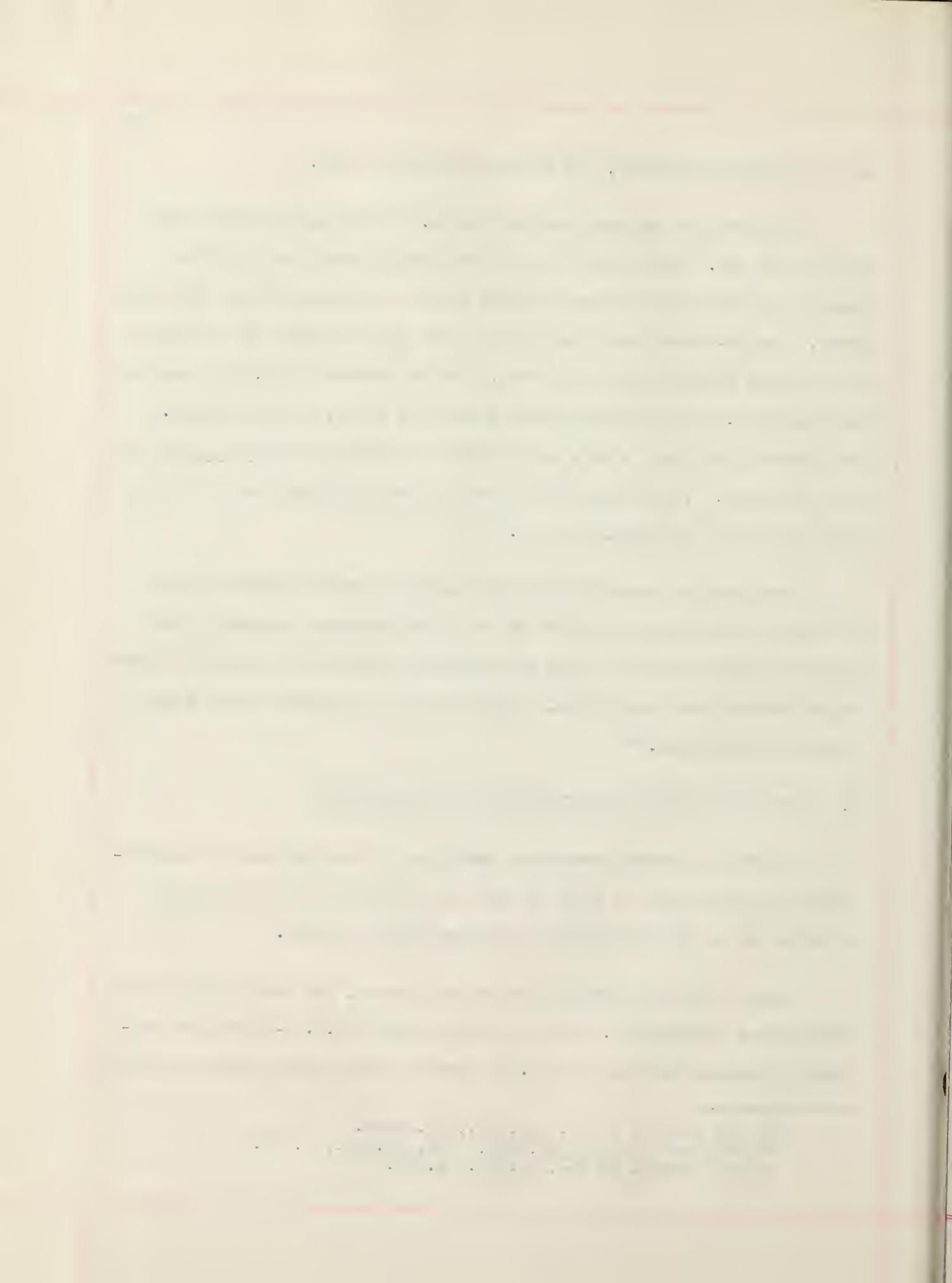
Before the actual techniques employed in neuropsychiatric examinations are considered, it would be well to list some of the diagnostic criteria set up by the National Selective Service System.

After the Selective Service Law was passed, the Army published its Mobilization Regulations. Part of this document (M.R. 1-9) defined criteria for exclusion from service.³⁶ Several months later Medical Circular

34 von Storch, et al., op.cit., pp.893-4.

35 Sullivan, Psychiatry, May, 1941, op.cit., p.205.

36 von Storch, et al., op.cit., p.893.



Number One was published to unify diagnostic viewpoints and practises.³⁷ It listed eight types of gross peculiarities that local board examiners should watch for.³⁸ These eight gross categories have since been defined and refined by several outstanding psychiatrists. Sullivan,³⁹ quoting from this Medical Circular, defined a chronic alcoholic as one who "habitually or recurrently used alcohol to the point of social disablement as evidenced by loss of jobs, repeated arrests, or a verified history of either repeated hospital treatment for acute alcoholic intoxication or institutional care because of chronic alcoholism."

Among the more disqualifying criminal offenses are rape, sex perversions, drug addiction, chronic alcoholism, and others which are characteristic of the constitutional psychopathic types.⁴⁰

As for minimum mental capacity required, registrants must have completed at least the fourth grade in school.⁴¹ Sullivan⁴² states that a Mental Age of ten years or less should disqualify a man, and one of ten to twelve years where personality disorders exist as well, should also be disqualifying.

One group of authorities,⁴³ including the Chief Medical Officer of the Massachusetts State Selective Service System, lists several important signs of instability, as follows:

37 cf. p.29.

38 cf. p.30.

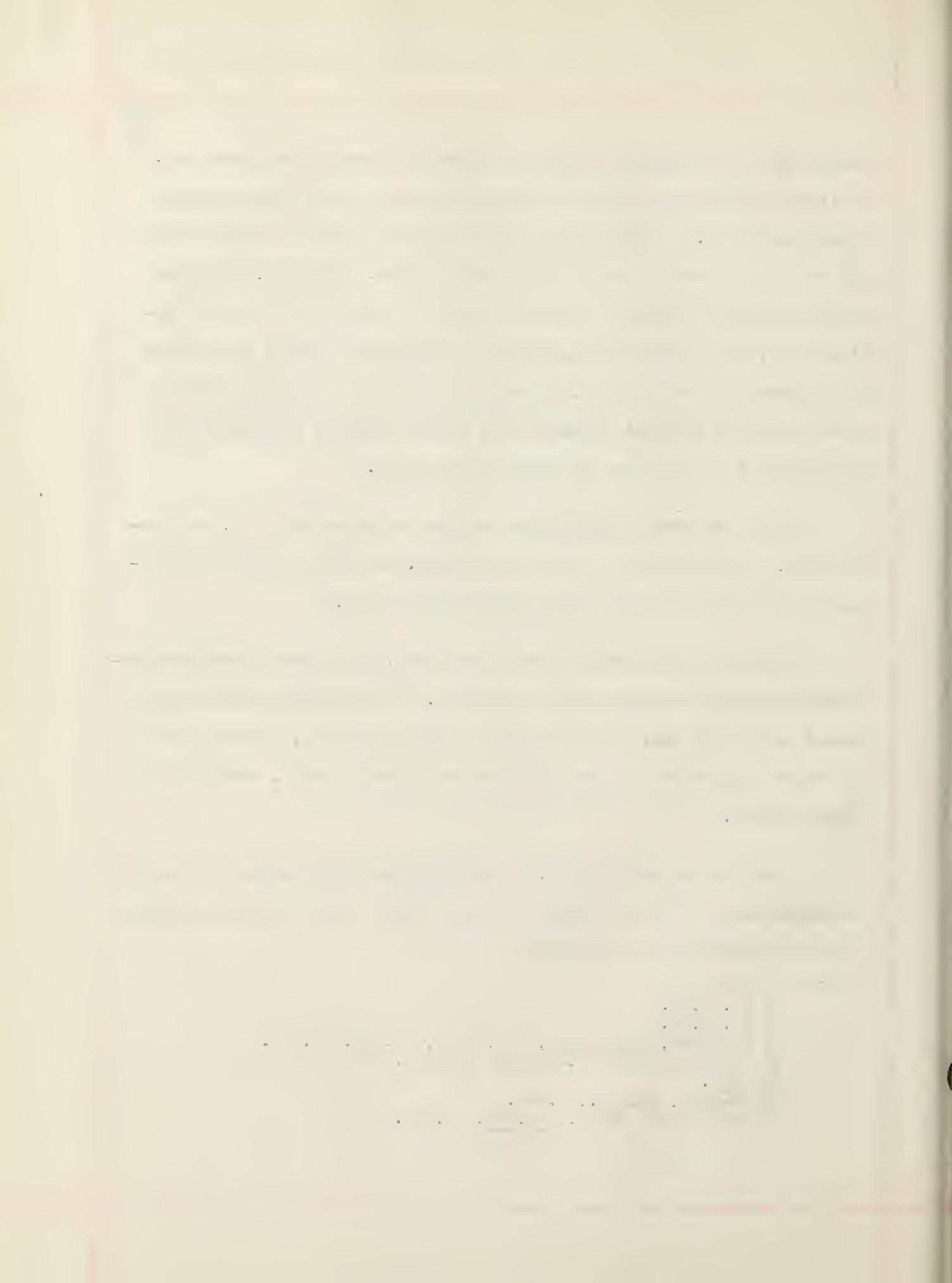
39 Sullivan, Psychiatry, May, 1941, op.cit., p.213.

40 Interview with Lt.-Colonel Currier.

41 Ibid.

42 Seminar, op.cit., p.271.

43 von Storch, et al., op.cit., p.895.



Addiction to drugs or alcohol, chronic complaints, gastric neuroses, cardiac anxiety, litigation neuroses, frequent change of occupation or residence, easy fatigability, repeatedly poor scholastic record, prolonged enuresis, urinary dribbling, lack of acquaintances, withdrawal from social contacts, fanatic beliefs, and overly aloof attitudes during the examination.

To this long list Bowman⁴⁴ adds divorce, details of personality appearance, and long periods of hospitalization. Sullivan⁴⁵ adds: psychotic relatives in the immediate family, and homes broken by death, divorce, etc. before registrants reached the age of thirteen. Kardiner⁴⁶ reports that stammerers, persons with tics, those with histories of convulsive seizures; "fainty" men and those hating the sight of blood; men with low cardiac reserve, with chronic disturbance of the autonomic system, or without tolerance for physical pain are all potential traumatic neurotics in war.

Madigan⁴⁷ remarks that except in purely neurological cases, behavior offers more clues than physical symptoms, because mental and nervous diseases frequently exist in persons physically strong and active, and apparently healthy. Bullard⁴⁸ further clarifies this point by urging that men showing any signs of the various forms of tension should be segregated for further study. Smith⁴⁹ makes the keen observation that the "attitudes of a man towards his symptoms and how he handles them are often more important than the symptoms themselves."

The problem of malingers is a serious one.⁵⁰ One group of wri-

44 Reese, Lewis, and Sevringshaus, Year Book of Neurology, Psychiatry, and Endocrinology (Chicago: Year Book Publishers, 1941), p.433.

45 Sullivan, Psychiatry, May, 1941, op.cit., pp.204-5.

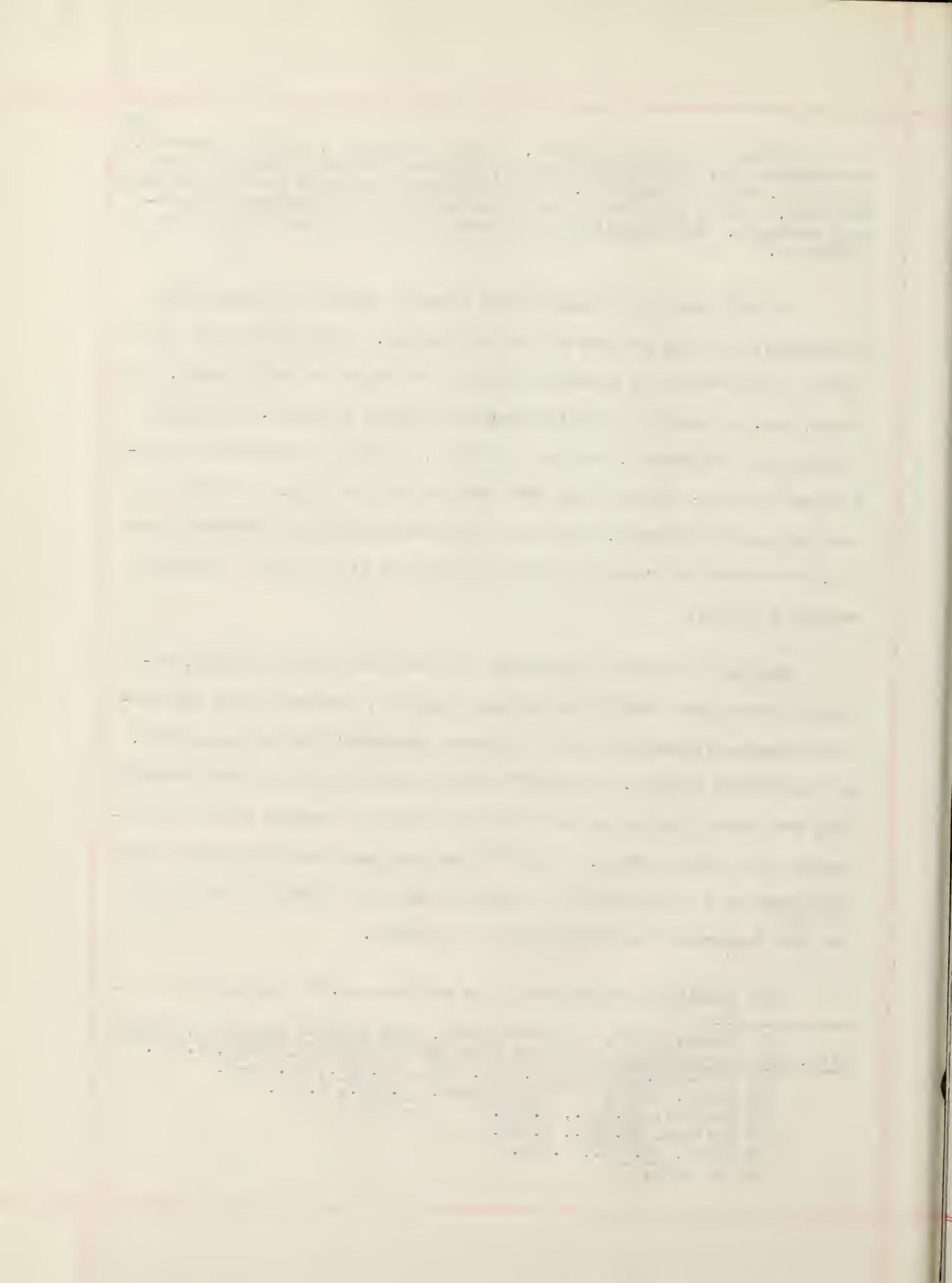
46 Reese, Lewis, and Sevringshaus, op.cit., p.433.

47 Madigan, op.cit., p.227.

48 Bullard, op.cit., p.242.

49 Smith, op.cit., p.249.

50 Cf. p.11.



ters⁵¹ points out that healthy-minded malingers try to evade service by unjustly claiming dependents, whereas the genuine malingerer feigns physical or mental illness. Such a man is no good for the Army, because he will do the same thing there.

The same writers summarize the whole problem of diagnostic criteria thus:

A man of the Selective Service age . . . who has made a satisfactory social adjustment, had no trouble in school, has worked steadily without frequent interruptions because of ill-health, has no police record, and who shows no evidence of nervous or mental disorder, will not, in the great majority of cases, break down under stress of army life.⁵²

With these diagnostic criteria in mind, how do psychiatrists go about detecting defects in registrants?

On the basis of experience in the last war, psychiatrists estimate that at least five per cent of registrants will probably be neuropsychiatrically disabled.⁵³ Some psychiatrists, aware of the increased stresses in modern warfare, and of the reduced stability of American youth,⁵⁴ raise this estimate to eight percent. Eager to eliminate these men before they break down, psychiatric examiners do their best to detect them before induction.

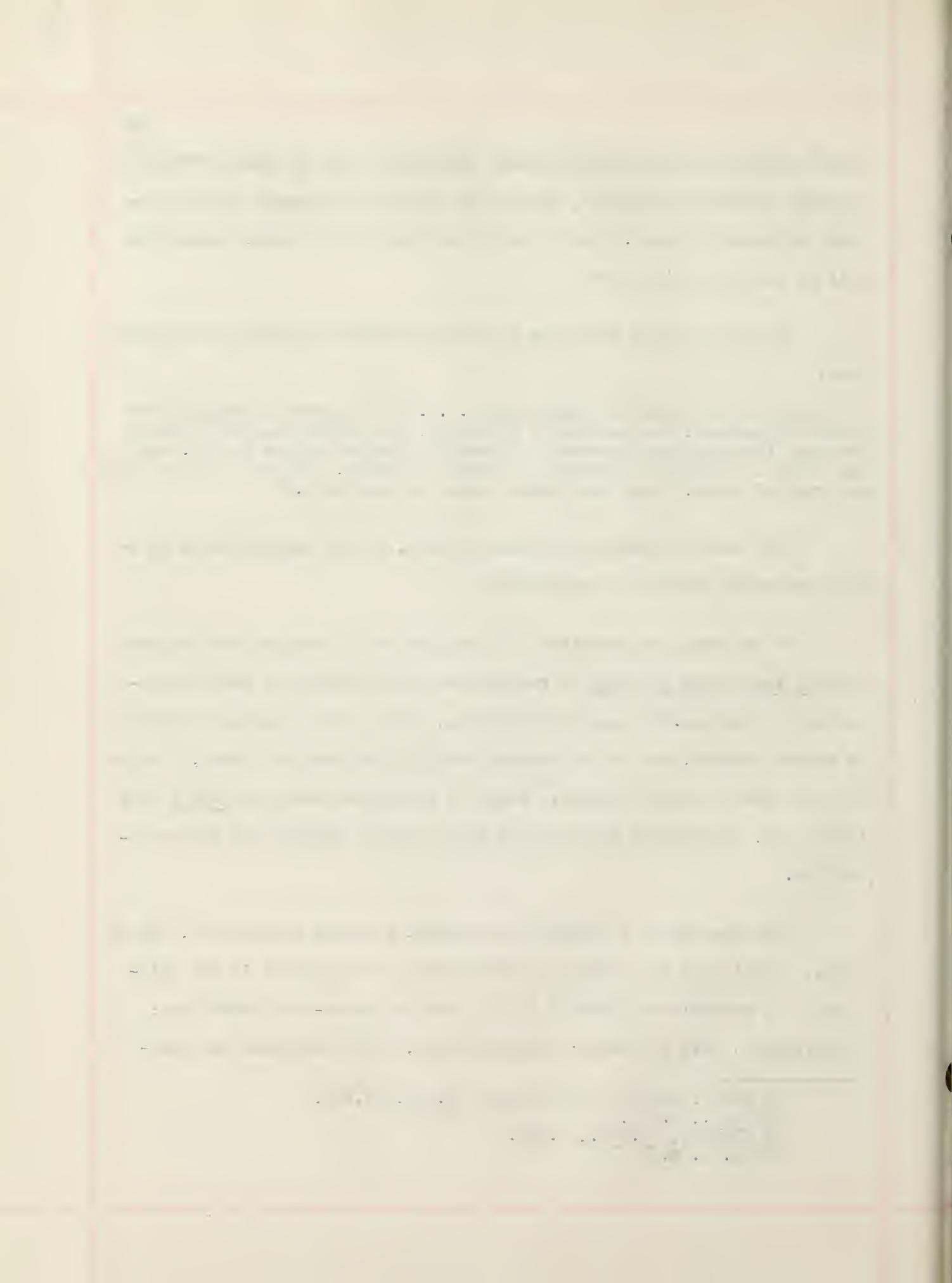
This they do by a testing of reflexes, by acute observation, and by direct questioning to elicit any difficulties of registrant in his relations with others; with himself in his work and spare-time activities; with friends, male or female; with employers, etc. They also ask ques-

51 Keene, Hassell, and Miller, op.cit., p.514.

52 Ibid., p.513.

53 Seminar, op.cit., p.266.

54 cf. p.22.



tions about any bad habits registrants may have and their ability to break them, about their degree of self-esteem, and about the opinions their friends have of them, etc.⁵⁵

Others⁵⁶ add questions regarding head trauma, unconsciousness, convulsions, and nervous breakdowns. Sullivan⁵⁷ suggests referral to advisory board psychiatrists for consultation of registrants manifesting any of the following deviations:

Instability, seclusiveness, sulkiness, sluggishness, discontent, loneliness, depression, shyness, suspicion, over-boisterousness, timidity, lack of initiative and ambition, personal uncleanliness, stupidity, dullness, resentfulness to discipline, a history of nocturnal incontinence, sleep-walking, sleeplessness, recognized queerness, suicidal tendencies either bona fide or not, homosexual proclivities, and attempts at malingerer.

Smith⁵⁸ recommends observation of the general attitude and behavior of the registrant during examination, as these are significant and revealing.

If these techniques are skillfully used, then, in the opinion of Sullivan,⁵⁹ "a psychiatrist, once oriented to the special problems that confront him, once clear on the standards to be used, and having fifteen minutes per patient, can reduce future disabilities by about 54 per cent."

But certain conditions obtain which preclude a maximum use of these techniques. Many local board examiners continue to be insensitive to the implications of signs and symptoms of personality handicap,⁶⁰ and many local boards on which they serve still regard psychiatrists as feeble-

55 Sullivan, Psychiatry, May, 1941, op.cit., p.213.

56 von Storch, et al., op.cit., p.895.

57 Sullivan, Psychiatry, May, 1941, op.cit., p.217.

58 Smith, op.cit., p.243.

59 Seminar, op.cit., p.268.

60 Ibid., p.265.



minded persons who indiscriminately reject everyone sent to them.⁶¹ As a result, some medical advisory board psychiatrists have never had a registrant referred to them.⁶² Furthermore, psychiatrists aren't always clear about standards,⁶³ and some induction board psychiatrists have had to handle 150 to 250 registrants per day.⁶⁴ Concerning the change to the single examination system, Sullivan has this to say:

The change to the single examination means that the burden of psychiatric and personality selection now devolves wholly upon the medical department of the Army. Any continuing skepticism on the part of Army medical authorities as to the importance of mental and personality factors in qualifying registrants will now have disastrous consequences. Under no conceivable circumstances can satisfactory work be expected of psychiatrists who see candidates for an average of $2\frac{1}{2}$ minutes in the course of the pre-induction examination.⁶⁵ This quasi-inspection is better than nothing, so far as the quality and durability of Army enlisted personnel is concerned. So far as psychiatry itself as a medical discipline significant in the intelligent mobilization of man power is concerned, it is decidedly worse than useless. It is an incompetent make-shift that does far too little far too late in the process of mobilization to eliminate the most troublesome elements.⁶⁶

When we consider that induction board specialists, who formerly examined only those passed as fit by local board physicians, must now also handle the many thousands of men who, under the earlier system, would have been rejected by local board examiners and thus would never have reached an induction board, we must admit that Sullivan's denunciation of the new system, however vitriolic, may have some justification.

61 Sullivan, Mental Hygiene, op.cit., p.12.

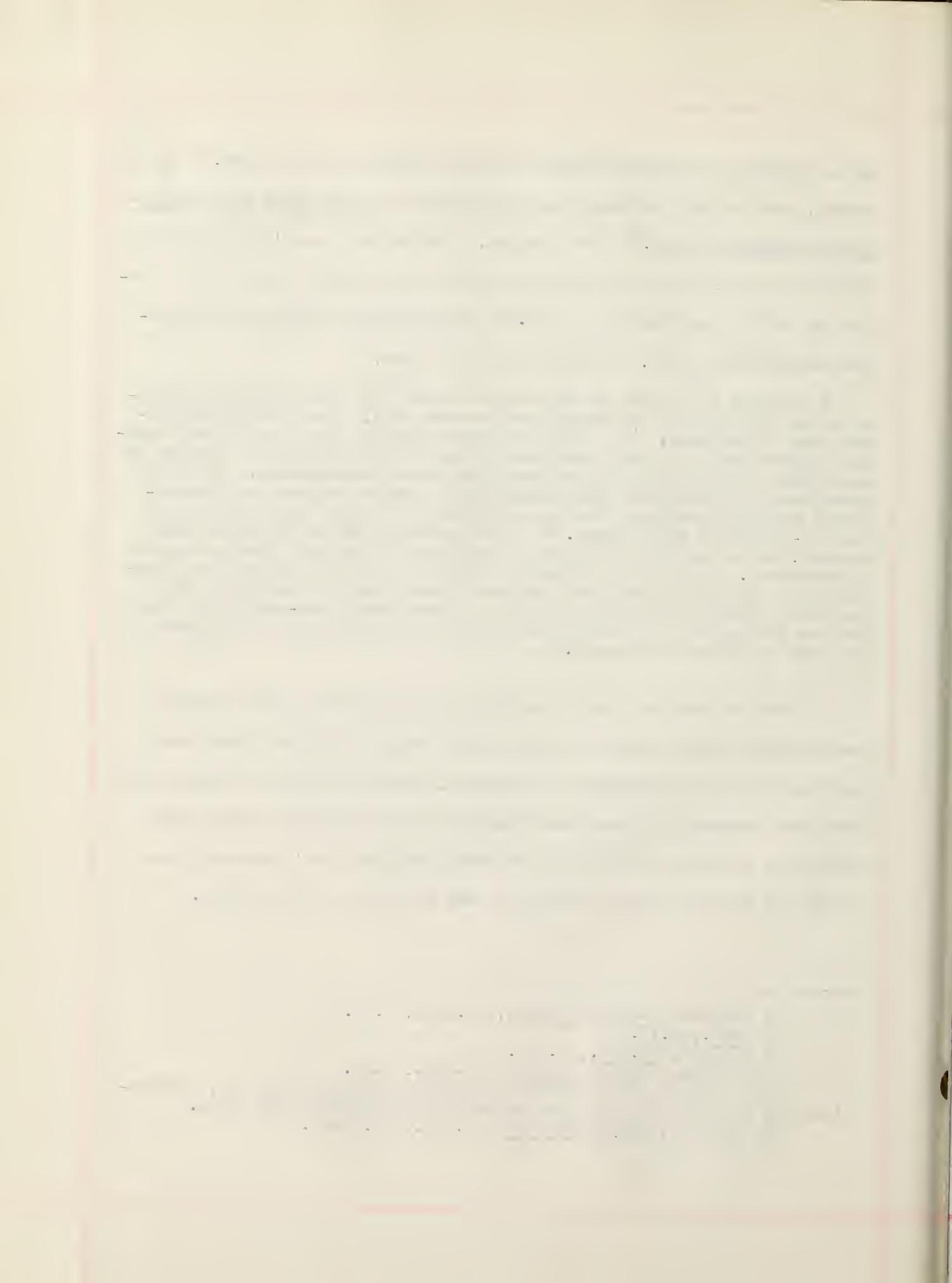
62 Ibid., p.12.

63 Seminar, op.cit., p.265.

64 Sullivan, Mental Hygiene, op.cit., p.12.

65 If this was true before we entered the war, then now, when mobilization is being rapidly accelerated, it is probably more true.

66 Sullivan, Mental Hygiene, op.cit., pp.13-14.



CHAPTER IV

THE NEED FOR SOCIAL SERVICE INVESTIGATION

I DIFFICULTIES IN DETECTING DISABILITIES

The difficulties confronting psychiatrists mentioned in the previous chapter were all due to external, organizational causes. In addition, there are some outstanding difficulties that inhere in the very nature of the defects.

In the examination of selectees, certain of the crude neuropsychiatric categories can be detected in over fifty per cent of the cases. But there are three major and common types of disabilities which are detectable in so short a period only by fortunate accidents. These are represented by the psychopaths, the hysterics, and the cyclothymics (mood disorders). The cyclothymics can't be detected unless they are experiencing a noticeable mood swing during the examination period. Since this period is so brief, the chances that such a fortunate accident will occur are discouragingly slim. The hysteric is always keyed up to meet any novel situation with enthusiasm and interest, hence, great sensitivity is required to detect him.¹ The psychopath, too, is difficult to detect because he doesn't present neurotic symptoms,² and because he conceals his past history of difficulty with the environment. He is frequently a fine physical specimen with a good intelligence who is eager to get into the Army because he feels that it offers economic independence from his family, escape from repeated failures in civil life, and the satisfaction of a desire to play soldier. Hence he tries, and often succeeds, in making a favorable first

¹ Sullivan, Psychiatry, May, 1941, op.cit., p.208.

² Dunn, op.cit., p.257.



impression.³

Concrete evidence of the above statements is offered by William Baillie in his study of 200 neuropsychiatric admissions from the Canadian Army Service Forces in this war.⁴ He reports that thirty-five per cent of these men were diagnosed as psychopaths. The fact that in our own Army hospitals there were, on the week ending August 30, 1941, 2,164 patients with all kinds of mental, nervous, and neurological disabilities,⁵ may be due, in part, to the difficulty of detecting certain types of disabilities. This probably also explains, in part at least, the statement that psychiatrists in selective service expect to miss somewhere about fifty per cent of the neuropsychiatric disabilities that will appear before the examined men will be through with the government service.⁶

II THE NEED FOR SOCIAL HISTORIES

After the last war, the frequency among neuropsychiatric breakdowns of a positive family history and of factors predisposing to psychoneurosis⁷ led many psychiatrists to conclude that social histories are essential in all neuropsychiatric examinations. Evidence compiled during this war corroborates this view.

One writer⁸ describes a recent study of 183 admissions to St. Elizabeth's Hospital from the Army, Navy, Marine Corps, and Coast Guard from

3 Dunn, op.cit., p.257.

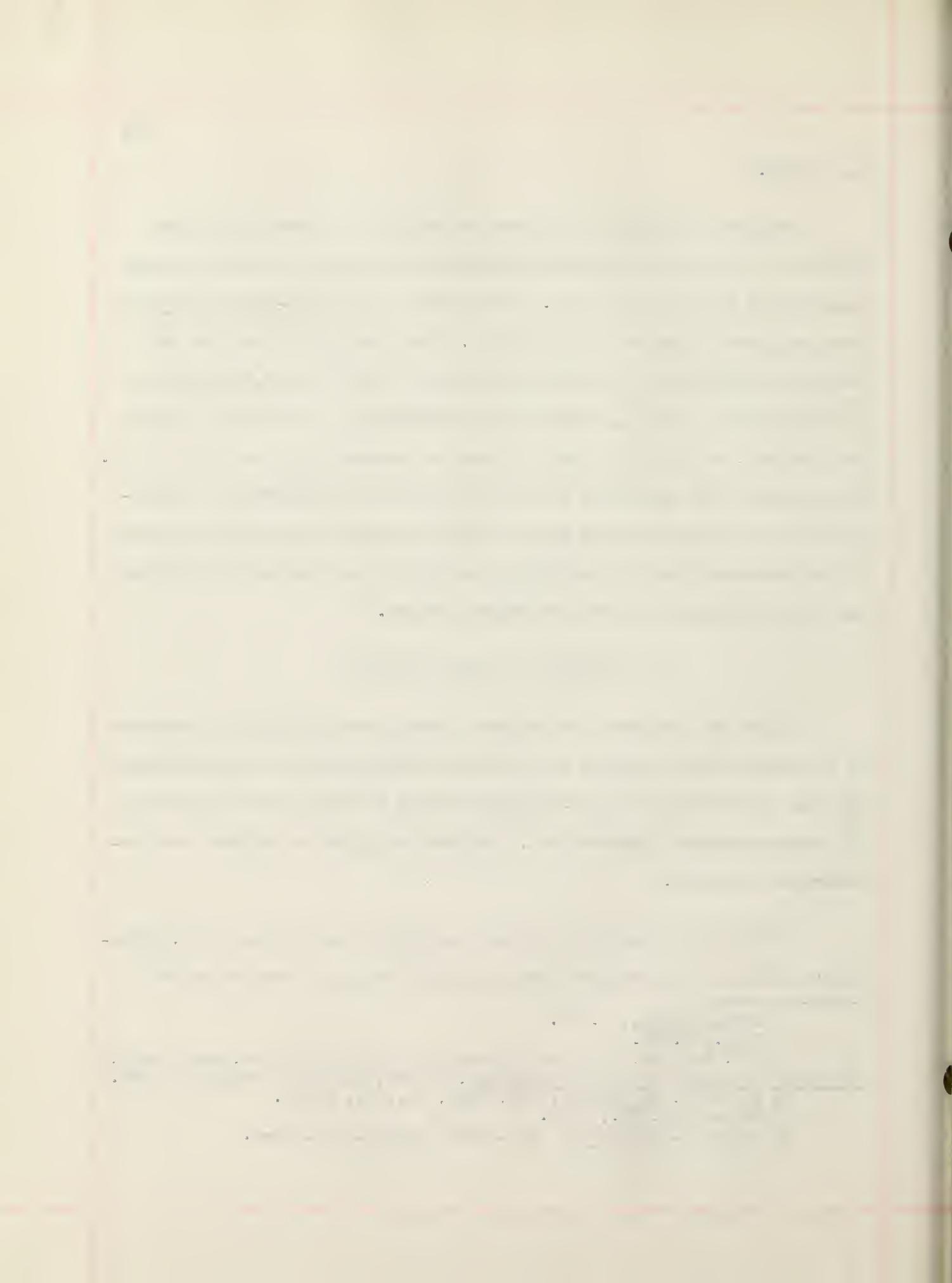
4 Ibid., p.253.

5 P.S. Madigan, "Military Neuropsychiatry, Discipline, and Morale," Journal of Criminal Law and Criminology, 32:494, January - February, 1942.

6 Sullivan, Psychiatry, May, 1941, op.cit., p.210.

7 Miller, op.cit., p.20.

8 Sullivan, Psychiatry, May, 1941, op.cit., pp.204-5.



October 1, 1939 to September 30, 1940. All were voluntary enlistees.

Forty-six per cent of them showed evidence of potential psychosis in their social histories.

Because of these conditions, many outstanding psychiatrists now working within the Selective Service System are emphasizing the need for social histories as a part of the routine of the neuropsychiatric examination.

Thus Sullivan⁹ points out the need for social histories in detecting psychopaths, hysterics, and cyclothymics; Dunn,¹⁰ in his discussion of psychopaths in the Army, stresses it likewise; and Cooley¹¹ underscores the value of such histories as preliminaries to neuropsychiatric examinations. Bowman¹² suggests taking a complete history for borderline cases, including hospital, court, social service, occupational, and school records.

To sum up in the words of one writer:¹³ "Only the most obvious neuropsychiatric cases can be found under our present system. Many of these men have probably been previously known to health, welfare, and educational agencies. Perusal of their records should aid the boards a great deal."

III RECENT EVIDENCES OF THE VALUE OF SOCIAL HISTORIES

Several studies have recently been made of situations where social histories were gathered and used as a part of a neuropsychiatric examination. A brief review of the results of some of these studies might be

9 Ibid., p.208.

10 Dunn, op.cit., p.257.

11 Cooley, op.cit., p.262.

12 Seminar, op.cit., p.432.

13 Sullivan, Mental Hygiene, op.cit., p.14.



instructive.

At Fort Snelling, Minnesota 9,652 registrants were examined during a given period. The records of the first 4,500 accepted men were searched. About twenty per cent of these men were prognosticated as questionable or fair material for the Army on the strength of the evidence contained in their records. Seventy per cent of these men showed evidence in their records of disabilities not always readily detectable in a brief examination: significant family histories, definitely below-average intelligence, psychoneuroses and psychosomatic disorders, and only fair adjustment to the Army prior to reaching the examiner.¹⁴

In Rhode Island, where induction board examiners were given social data as diagnostic aids, they rejected, on the average, 25.1 per cent of all registrants on neuropsychiatric grounds. The two most frequent causes of rejection were anxiety hysteria and effort syndrome, again two defects all-too-infrequently detected.¹⁵ The writers conclude that the above examination system seems to be reducing the number of neuropsychiatric casualties in the Army.¹⁶

On the basis of these and similar studies, as well as experience in the last war, Bowman¹⁷ advises the securing of records through social service registers, state hospital systems, and the like. He goes on to say that every psychiatrist knows that this historical material is the only means that we have of picking up a number of these cases, and that psychiatric records would enable boards to reject certain men without

14 Reese, Lewis, and Sevringshaus, op.cit., p.430.

15 Kiene, Hassell, and Miller, op.cit., pp.510-12.

16 Ibid., p.514.

17 Seminar, op.cit., p.282.



further study by any psychiatrist.

In the words of another psychiatrist,¹⁸ "A social history giving trustworthy information regarding intelligence, past health, character, and occupation would keep many unfit men out of the military service."

IV CURRENT EXPERIMENTS IN THE USE OF SOCIAL SERVICE INVESTIGATION

The value of using social service investigation of recorded data to implement neuropsychiatric examinations is becoming increasingly recognized. Several State Selective Service Systems have already adopted it as a part of their regular examination routine, and other states are planning to do likewise.

In Maryland, the names of all registrants are cleared through the office of the Commission of Mental Hygiene, and those persons found to have had residence in either public or private institutions in the state are so reported to the local boards.¹⁹

In Rhode Island, the Selective Service System has arranged to have social data gathered on hospital admissions and police records, and family physicians are seen, too.²⁰

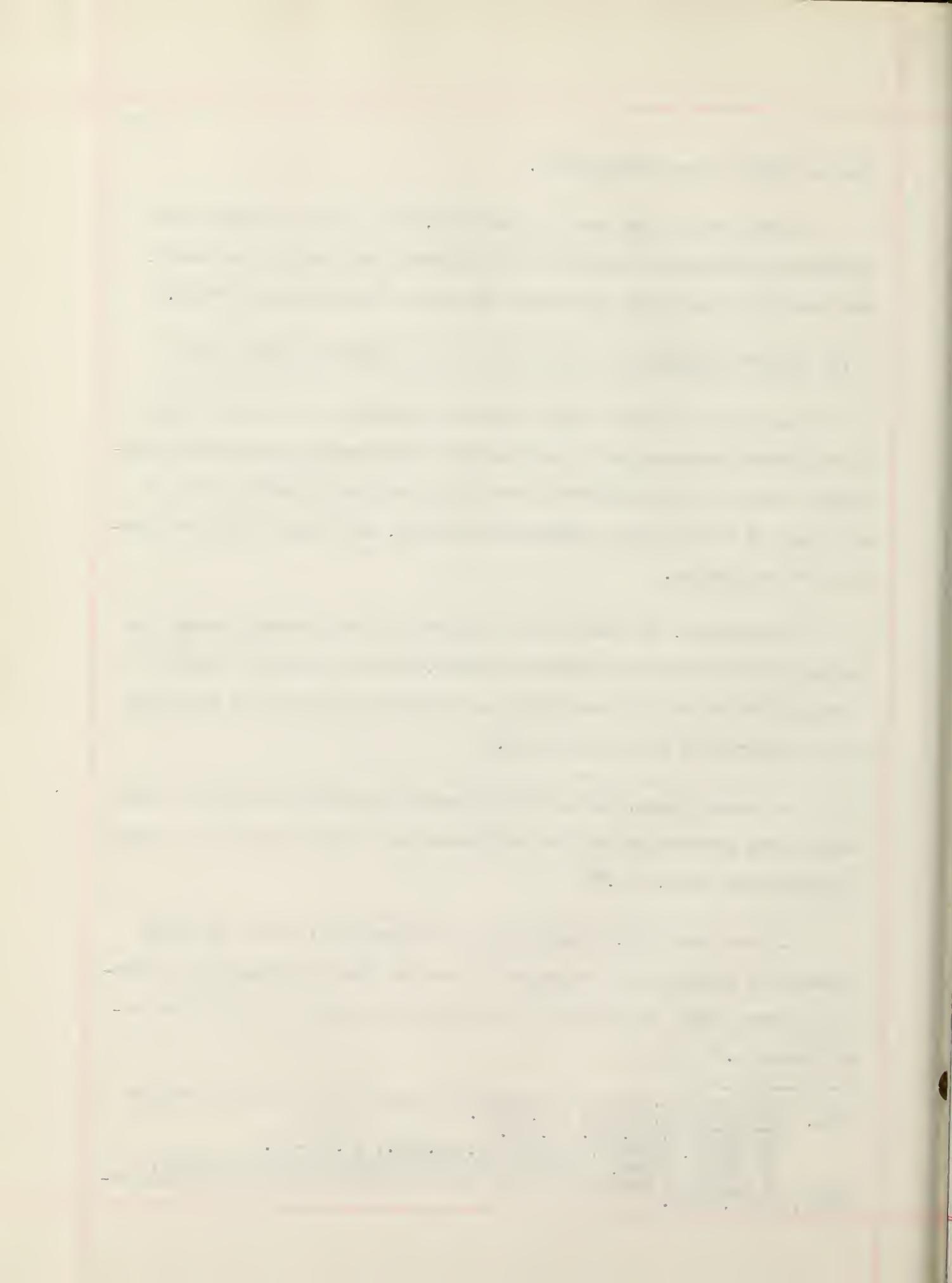
In New York City, local boards are referring all cases on which psychiatric evaluation is requested to the New York City Committee on Mental Hygiene, which has enlisted the volunteer services of psychiatric social workers.²¹

¹⁸ Joseph H. Pratt, "Psychiatric Factors in the Medical Examination," War Medicine, 1:363, May, 1941.

¹⁹ Bullard, op.cit., p.239.

²⁰ Kiene, Hassell, and Miller, op.cit., pp.511-12.

²¹ Marian McBee, "Selected Case Investigation at Local Level," Report of Executive Secretary of the New York City Committee on Mental Hygiene, April, 1942.



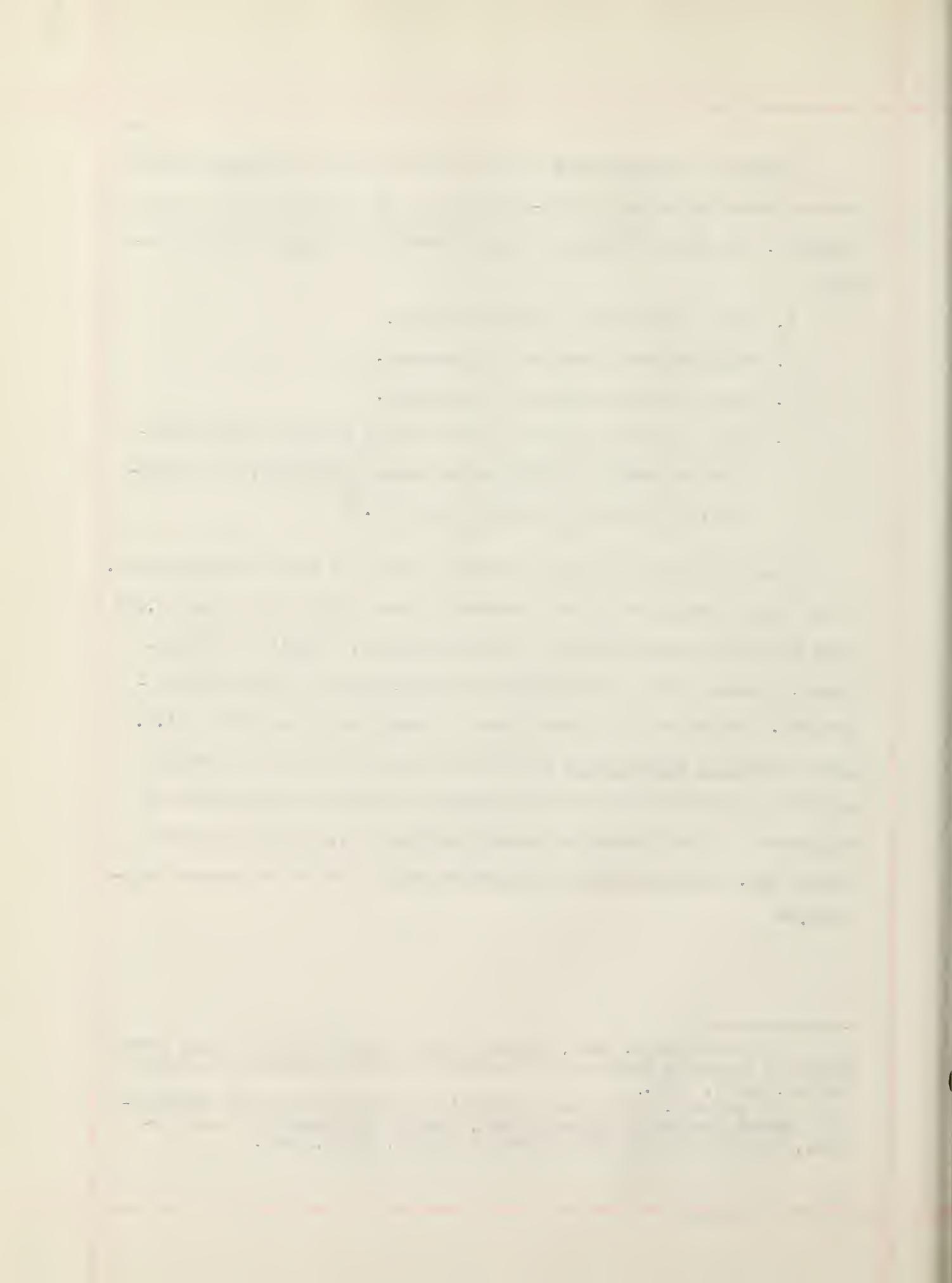
Plans are now being made in New York to organize a routine social service investigation on a state-wide basis. The proposed plan is quite ambitious. It aims at securing social histories for all registrants except:

1. Those with obvious physical defects.
2. Those deferred because of dependency.
3. Those deferred because of occupation.
4. Those positively known by local boards to have shown no evidence of mental disorder or deficiency, epilepsy, drug addiction, or serious personality disorder.²²

One of the older and more advanced schemes is found in Connecticut. It has been in existence there for about a year, during which time 45,000 names have been cleared with all mental hospitals, schools for feeble-minded, special classes for retarded children, and the state police department. The names of all men placed by local boards in class 1 (i.e. prior to medical examination) are routinely sent to the State Committee on Mental Hygiene which does the clearing by means of a master file of all present or past inmates of mental hospitals etc. now of selective service age. The Department of Education and the Police Department cooperate.²³

22 Katherine G. Ecob, "Routine Case Investigation at Local Level," Report of Executive Secretary of the New York State Committee on Mental Hygiene, April, 1942.

23 James H. Cunningham, "Detection of Neuropsychiatric Disabilities Through the Use of Recorded Data," Report of Bureau of Mental Hygiene, Connecticut State Department of Health, April, 1942.



V THE MASSACHUSETTS EXPERIMENT²⁴

On December 27, 1941 Lt.-Colonel Donald Currier M.D., Chief Medical Officer of the Massachusetts State Selective Service System, and Dr. Wilfred Bloomberg, in charge of procuring psychiatric service for the Boston Induction Center, requested the New England Division on Psychiatric Social Work to undertake an experimental social service investigation for a period of one month. There were to be two parts to this experiment:

1. Demonstration work with men referred as "suspect" by psychiatrists in all three state induction boards.
2. A research study of an unselected group from the Boston Induction Board only.

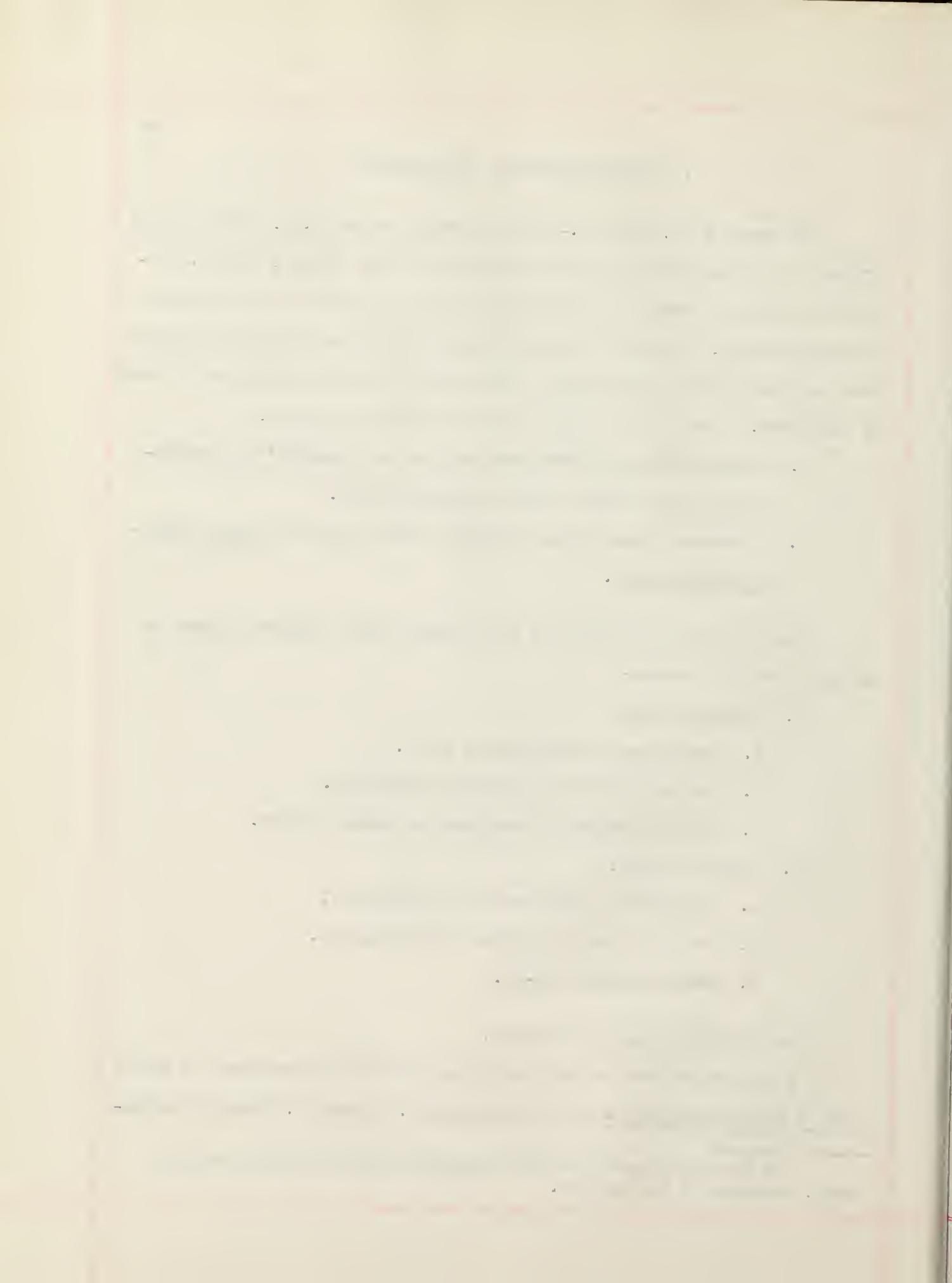
The New England Division of Psychiatric Social Workers planned to do these studies through:

1. Clearance with:
 - a. The Boston Social Service Index.
 - b. The Massachusetts Probation Commission.
 - c. The Massachusetts Department of Mental Health.
2. Interviews for:
 - a. Psychiatric social case work diagnosis.
 - b. Finding clues for further investigation.
 - c. Rehabilitation tie-up.

The following plan was devised:

Four workers were to get permission from their executives to devote half of their working time to this experiment. Marian M. Wyman, Case Con-

24 All the material on this experiment was contributed by Miss Wyman, director of the project.



sultant of the Boston Family Welfare Society, was to serve as director of the project and as case worker. Bernice Henderson, Educational Secretary of the Massachusetts Society for Mental Hygiene, was to be in charge of the research project and to do case work. Two other workers were to do case work as their half-time job.

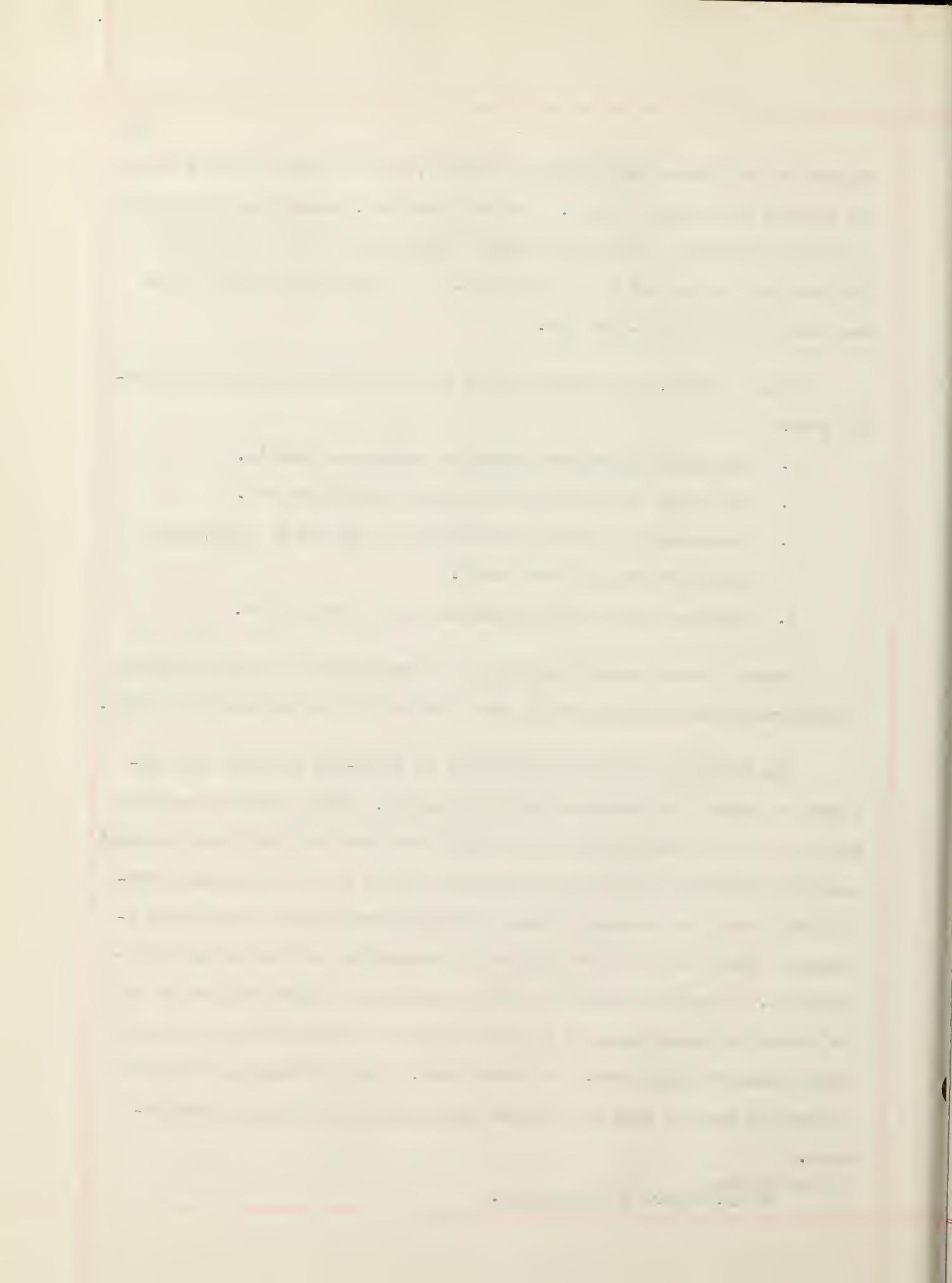
Other workers, as available, were to be appointed to do the following jobs:

1. One worker to get the Probation Commission reports.
2. One to get the Department of Mental Health reports.
3. Four others to cover those agencies which had no psychiatric social workers on their staff.
4. Fourteen others to do part-time work in the office.

Several women formerly employed as stenographers in social agencies volunteered to do the stenographic work from half a day to two days a week.

The services of eighty-six workers in fifty-two agencies were enlisted to gather the necessary social histories. They agreed to read the records in their own agencies and to cull from them only pertinent material about the emotional and social adjustment as well as the biological heredity and social environment of each selectee known to their respective agencies. These workers were completely responsible for the choice of information. Since they were all trained psychiatric social workers or had the equivalent experience, it was felt that they were qualified to handle this assignment adequately. To assure this, a set of "working notes"²⁵ was sent to each of them to indicate just what type of material was desired.

25 cf. Figure 5 in appendix.



An advisory council was set up, consisting of the four half-time workers mentioned above and two others -- Mrs. Maida Solomon and Miss Esther Cook, both experienced in psychiatric service. This council discussed procedures at various stages.

This entire organization was set up in the course of one week mainly through the efforts of the director of the project, Miss Wyman.

At once it was learned that no routine interviews would be permitted, hence work continued on the other three sources of information. The need for interviews was felt throughout the study, and on the reports sent to Lt.-Colonel Currier on the individual selectees, mention was frequently made of the additional help that could be given if an interview would be requested.

Since there was some initial delay in getting material, the study was extended for an additional two weeks, thus covering the six-week period from January 8 to February 21, 1942.

Two men who were told by the induction board psychiatrists that they were being referred for social service investigation, came in for interviews on their own initiative. Four others were interviewed by request of their local boards. During the entire period, 109 men were referred for social service investigation; and 445 men, representing an unselected ten per cent sampling of all selectees examined by the induction boards, were referred for research. Of the former study group of 109 men, three couldn't be identified, leaving 106 to be studied.

Men with frank psychoses and feeble-mindedness were not referred for study, except when their condition was not definitely ascertained and



needed proof. Psychiatrists referred a selectee because they detected some problem in him, or because they saw some problem in his papers, either a court record or some disease claimed.

Since the channels to the local boards were not always open at first, the reasons for referral were not always available. Sometimes the local boards didn't know the cause of referral. As the use of the investigative service became known, these reasons for referral were more frequently given.

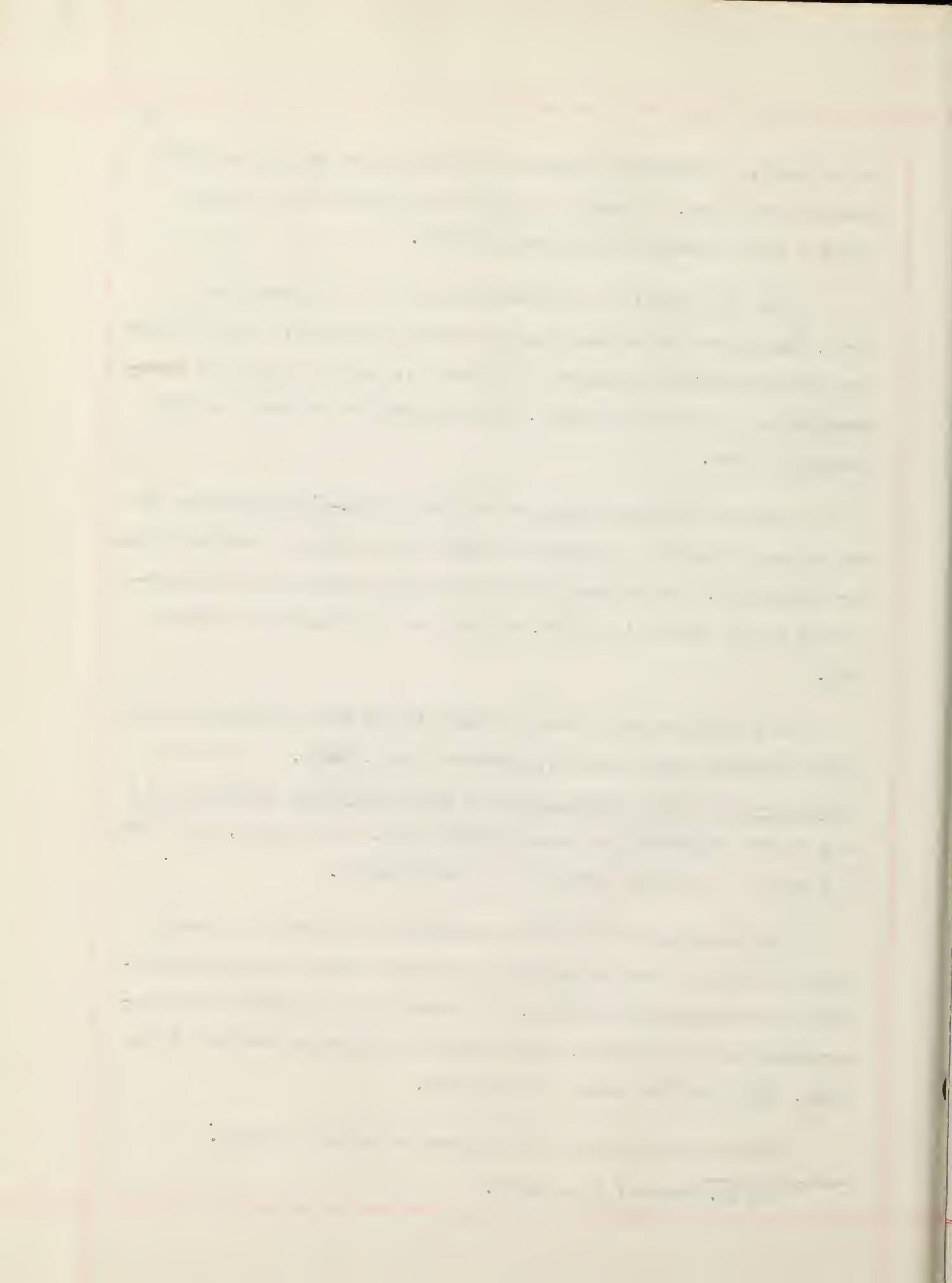
A report²⁶ on each study case was sent to Lt.-Colonel Currier who was to send it on to the appropriate local boards with his recommendations for disposition. The material culled from agency records was not incorporated in the selectee's record, but was used for diagnostic purposes only.

As a result of this study, on March 18 the State Selective Service System requested Local Board 16, Stanhope Street, Boston, to provide a routine social service investigation on every registrant classified as 1 as a further experiment and demonstration which, it was hoped, would lead to a general use of the service by all draft boards.

The investigator was asked to analyze for purposes of a thesis study the social histories compiled on the study group of 106 selectees. After discussion with Miss Wyman, the investigator discarded the six interviewed cases as atypical, hence likely to distort the results of the study. This left 100 cases to be analyzed.

The results of this analysis appear in the next chapter.

26 cf. Figure 7 in appendix.



CHAPTER V

ANALYSIS OF THE RECORDED DATA

I DATA AVAILABLE TO INVESTIGATOR

The following data were available to the investigator: some of the reasons for referral of selectees for social service investigation; their age, local board, and home town. This information was furnished by the local boards. With the help of these facts, the social workers gathered additional data on contacts of selectees and their families with social agencies using the Boston Social Service Index and related Indexes in other cities; on police and court contacts from the Probation Commission records; and on mental hospital contacts through the Department of Mental Health. This department had records on all residences in public or private mental hospitals in the state, on all contacts with state child guidance clinics, on all examinations of retarded children by traveling school clinics, and on all Briggs' ¹ law examinations of delinquents.

The evaluation of the psychiatric significance of all the above data was then made by Miss Wyman, director of the social service investigation project, who then made recommendations for interviews with selectees where she felt these were needed to make an adequate diagnosis.

Due to the specific, practical purpose of this study and the unavoidable haste with which it was carried out, several kinds of data that might have been of value in such a thesis study were not gathered, or were available only for some of the cases. The investigator felt that with

¹ Section 100A, Chapter 123 of the General Laws, providing for an investigation into the mental condition of certain persons held for trial.



most of the latter (e.g. occupations, nativity of parents, size of families, etc.) there were not enough data to permit safe generalizations, hence this material was, with one exception,² omitted. Also, since both the Department of Mental Health and the Probation Commission files are arranged by individual and not family names, it was impossible, in the time allotted, to get information on family contacts for many of the cases. Hence any data on court or mental hospital contacts of parents or siblings of the selectees were gathered indirectly through Index-using agencies, since the Index keeps files on families and has a cross-reference system.

Finally, the investigator had hoped to get the data on the ultimate disposition of these 100 cases by the local boards on the strength of the evidence contained in their social histories. Unfortunately, however, this material was not available in time to be included in the present thesis study. In lieu of this practical test of the value of these histories to selective service neuropsychiatrists, the investigator is using the evaluation of the psychiatric significance of these histories made by the director of the social service investigation project. Since this director, Miss Wyman, possesses keen, intuitive psychiatric insight and a wealth of psychiatric social work experience; and since she is president of the New England Division on Psychiatric Social Work, the investigator felt that he could assume the soundness of her professional judgment.

II ANALYSIS OF THE DATA

A. REASONS FOR REFERRAL

The initial step in the study was to find out just why these 100

² Size of families, known for half the cases.



selectees were referred for social service investigation, i.e. what the social workers were expected to discover or verify. Reasons for referral were available on eighty of the cases, and included 102 different suspected disabilities. These questioned disabilities are divided as follows:

TABLE IV

REASONS FOR REFERRAL OF MEN FOR SOCIAL SERVICE INVESTIGATION

Type of Suspected Disability	Number of Cases
Court record	14
Constitutional psychopathic personality	13
Epilepsy	13
Defects of unknown aetiology	13
Psychoneuroses	10
Chronic alcoholism	9
Organic nerve disease	9
Psychoses	8
Malingering	7
Mental deficiency	3
Acute alcoholism	3
Total	102

Seven of the above categories are readily understood, but four of them (defects of unknown aetiology, psychoneuroses, organic nerve disease, and psychoses) require further analysis. (Cf. TABLE V on next page).

B. AGE AND GEOGRAPHICAL DISTRIBUTION

The distribution of ages is shown in TABLE VI on page 49. This table reveals that two per cent of the men were under twenty-one years of age, only nine per cent were over twenty-eight, and eighty-nine per cent were from twenty-one to twenty-eight inclusive. The median age was twenty-five years and one month.

These men were referred by fifty-three local boards. Included in this group is Camp Devens Recruiting Center, since eleven of the 100 cases

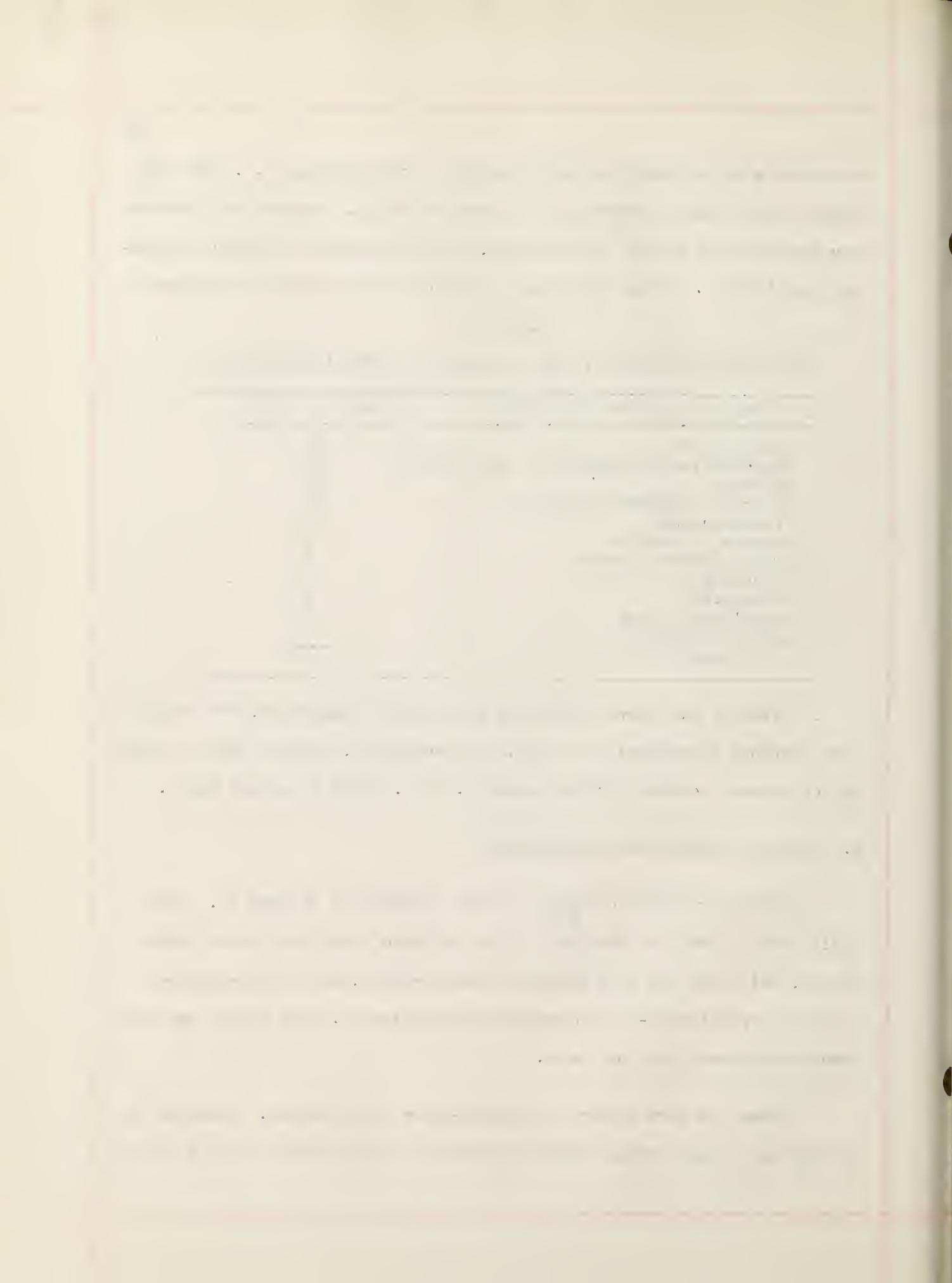


TABLE V

ANALYSIS OF FOUR CATEGORIES OF THE REASONS FOR REFERRAL

Suspected Disability	Number of cases
PSYCHOSES:	
Had been in Worcester State Hospital	2
Early schizophrenia	2
Psychosis	2
Schizoid personality	1
Manic-depressive personality	1
	<u>8</u>
PSYCHONEUROSES:	
Psychoneurosis	3
Neurocirculatory asthenia	2
Hysterical type	1
Anxiety type	1
History of peptic ulcer	1
Enuresis	1
Sleep-walking and talking	1
	<u>10</u>
ORGANIC NERVOUS DISEASE:	
Post-traumatic cerebral syndrome	2
Parkinson's Disease	1
Traumatic synovitis, left knee, possible internal derangement	1
Post-encephalitic condition	1
Disturbance of vision due to early brain injury	1
Meniere's Syndrome	1
Cause and result of right facial paralysis	1
Back injury	1
	<u>9</u>
OF UNKNOWN AETIOLOGY:	
Headaches and/or nervousness	5
Dizzy spells	3
Family background	2
Syncope attacks	1
Hives	1
Tachycardia	1
	<u>13</u>

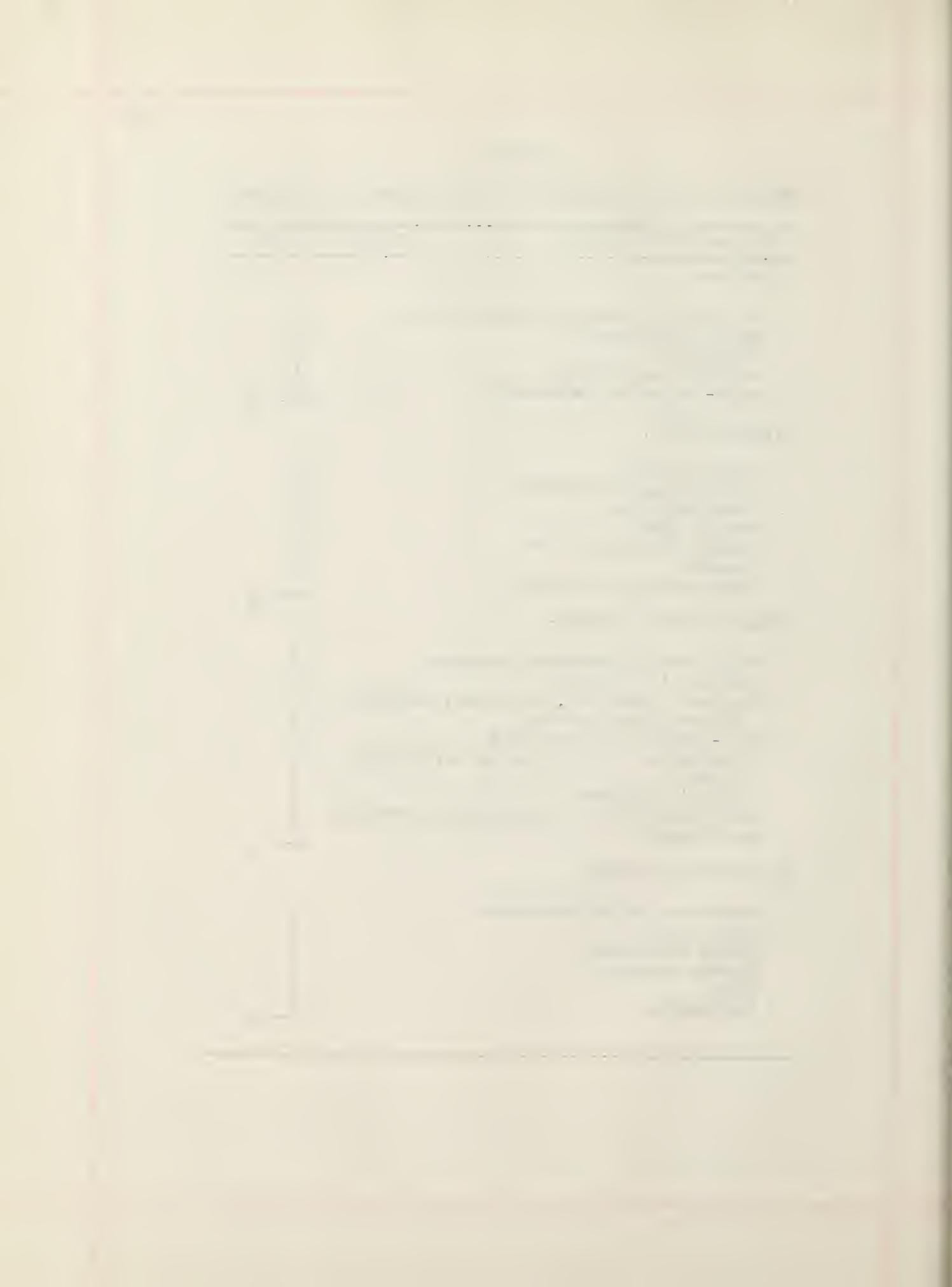


TABLE VI
AGE DISTRIBUTION OF SELECTEES

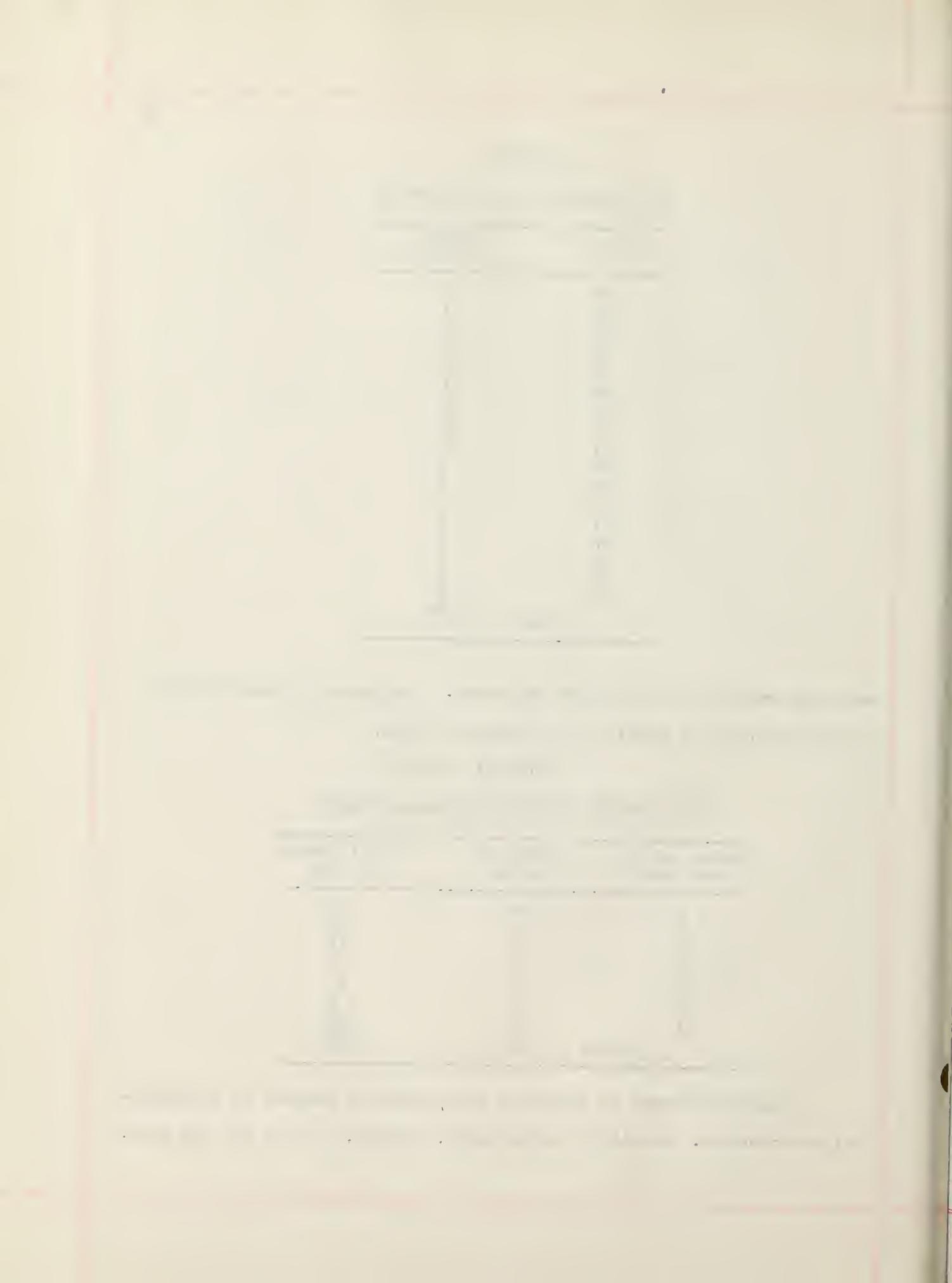
Age	Number of Cases
18	1
20	1
21	11
22	12
23	12
24	11
25	13
26	13
27	10
28	7
29	2
30	2
31	1
33	1
35	1
36	1
43	1
Total	100

were not draftees but voluntary enlistees. The number of men sent by different boards is shown in the following table:

TABLE VII
DISTRIBUTION OF MEN AMONG LOCAL BOARDS

Number of Men Per Board	Number of Boards	Total Number of Men
1	33	33
2	11	22
3	4	12
4	1	4
5	2	10
8	1	8
11	1	11
Totals	53	100

This table seems to suggest a high degree of scatter in geographical distribution. As will be shown later, however, this is not the case,



for many of the local boards listed above are situated in the same city.

C. RELATIONSHIP BETWEEN AVAILABILITY OF AGENCIES AND NUMBER OF CASES KNOWN TO THEM

Analysis of the number of selectees and their families who were known to Index-using social agencies shows the following:

TABLE VIII

NUMBER OF SELECTEES AND FAMILIES KNOWN TO SOCIAL AGENCIES*

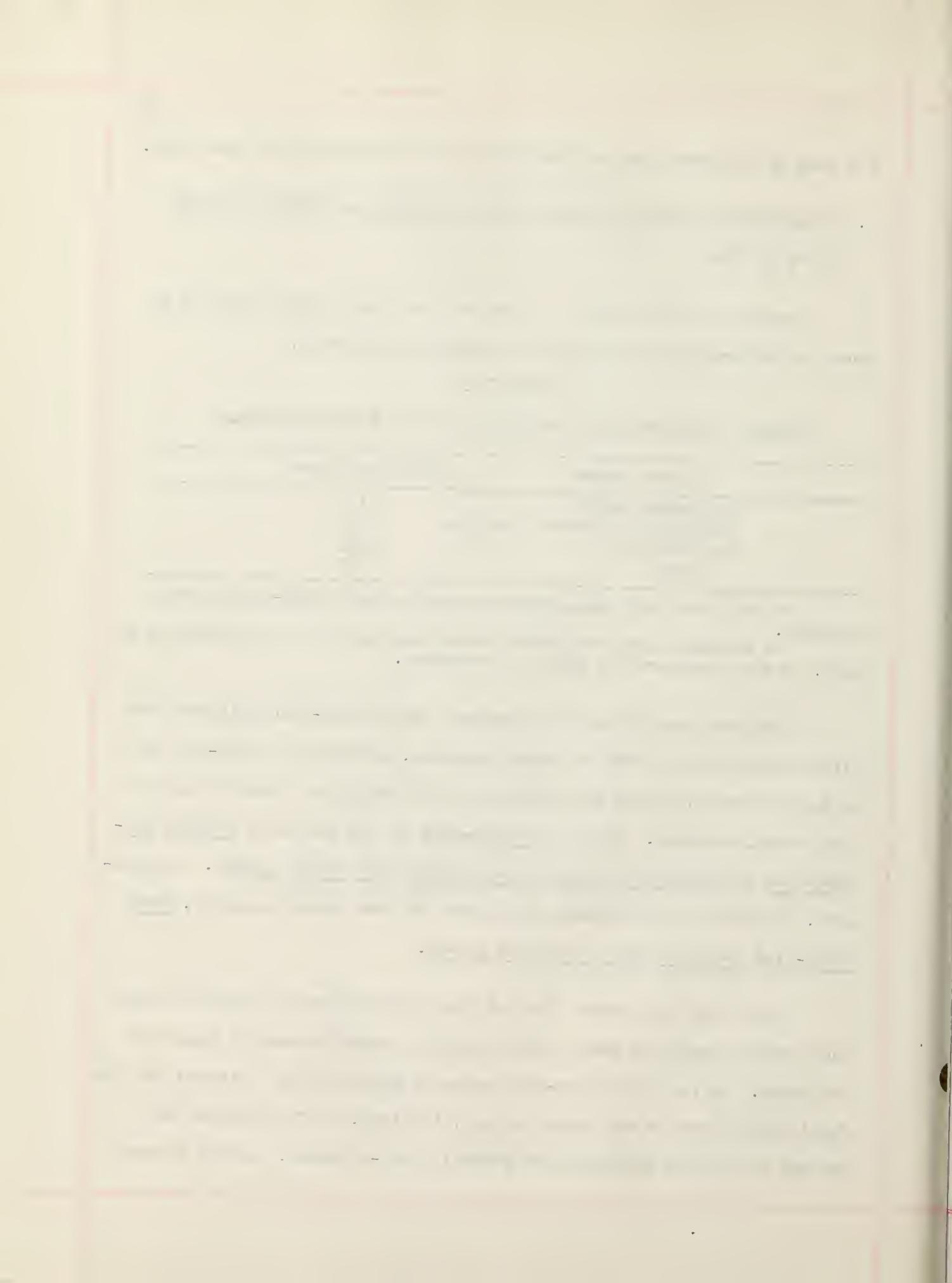
Persons Known	Number of Cases
Selectees only**	11
Selectees and their families	24
Families only	26
Total	61

* This term will henceforth be used to mean Index-using social agencies.

** Selectees are considered known when there is a registration on them, or when they are the focus of treatment.

From the above table it is evident that thirty-five selectees and fifty families were known to social agencies, and that in sixty-one out of the 100 cases, either the selectee or his family was known to one or more social agencies. Hence in thirty-nine of the 100 cases neither selectee nor his family was known to any Index-using social agency. Furthermore, if thirty-five selectees were known to some social agencies, then sixty-five selectees were not known to any.

What does this mean? Most of the selectees are too young to have been known directly to many social agencies, hence so many of them were not known. As for the thirty-nine cases in which neither selectee nor his family were known to any social agency, it might, at first blush, be thought that these selectees are probably well-adjusted, healthy members



of stable, self-supporting families who never needed the services of health and welfare agencies. But a second glance at the geographical distribution of these selectees raises an interesting point.

An analysis of population size in the various home towns and cities of these men shows the following:

TABLE IX
SIZE OF POPULATION IN SELECTEES' HOME TOWNS

Population Size	Number of Towns	Number of Cases
Over 100,000	6	47
50 - 100,000	6	18
25 - 50,000	6	8
10 - 25,000	13	16
Under 10,000	10	11
Total	41	100

This table shows that seventy-three per cent of the men came from cities or towns with populations of twenty-five thousand or more, and only twenty-seven per cent of them came from towns of less than twenty-five thousand people.

Further breakdown of these population figures reveals that whereas twenty-seven cities or towns contributed only one selectee among this group, one city, Boston, contributed thirty-two. This is probably largely due to the fact that while the Springfield Induction Center has the use of only two or three psychiatrists, Boston uses over forty of them in its induction station. Hence a higher rate of rejections and social service referrals are to be expected. Moreover, the distance of the other two induction stations from Boston, and the lack of familiarity of psychiatrists there with Boston psychiatric social workers probably tended to discourage too many referrals.



A study of the number of cases known by social agencies in towns of various sizes in relation to the total number of cases residing in these towns reveals the following:

TABLE X
PERCENTAGE OF CASES KNOWN TO SOCIAL AGENCIES

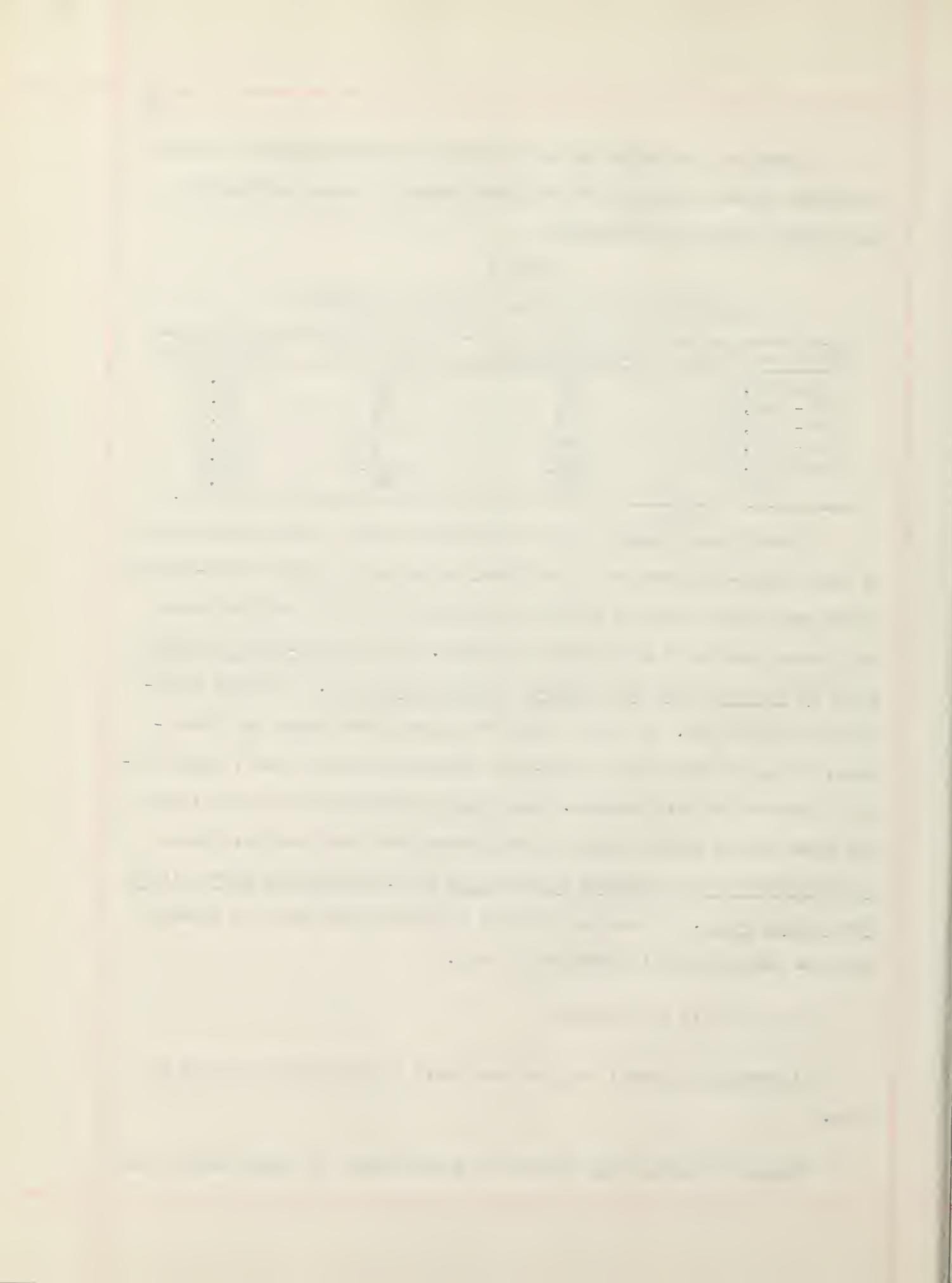
Population Size	Number of Cases	Number Known	Percentage
Over 100,000	47	36	76.6
50 - 100,000	18	12	66.7
25 - 50,000	8	6	75.0
10 - 25,000	16	4	25.0
Under 10,000	11	3	27.3
Totals	100	61	61.0

These figures reveal a most interesting fact: in the larger towns of over twenty-five thousand population, an average of about three-fourths of the cases were known to social agencies, while in the smaller towns only about one-fourth of them were so known. Hence three-fourths of the cases in smaller towns were unknown to social agencies. This may be expressed another way. If there were seven cases known among the twenty-seven living in towns with twenty-five thousand people or less, then twenty of these cases were unknown. And since thirty-nine cases in all were not known to any social agencies, this means that these smaller towns, which produced only a quarter of the cases (27), contributed over half of the unknown cases. To express it yet a third way, the ratio of unknown cases in large and small towns was 1 to 3.

How can this be explained?

A perusal of mental hospital and court records seems to offer a clue.

Eleven selectees were known to the Department of Mental Health, and



fifty-two were known to the Probation Commission. A relating of the number of cases known by the Department of Mental Health and by the Probation Commission to the total number of cases in the respective home towns is most revealing:

TABLE XI

PERCENTAGE OF SELECTEES KNOWN TO DEPARTMENT OF MENTAL HEALTH AND
TO PROBATION COMMISSION

Population Size	Total Number of Cases	Number Known To:			
		D.M.H.	M.P.C.	Number	Percentage
Over 100,000	47	5	10.6	30	63.8
50 - 100,000	18	2	11.1	10	55.6
25 - 50,000	8	2	25.0	5	62.5
10 - 25,000	16	2	12.5	2	12.5
Under 10,000	11	0	0	5	45.5

The figures above show clearly that the small town cases, relatively unknown though they might be to health and welfare agencies, are relatively far less unknown to the police and, to a somewhat lesser extent, to mental hospitals or child guidance clinics. This implies, does it not, that the small town selectees have problems to about the same extent as do those in large cities. Wherein, then, lies the crucial difference? It probably lies, in part, in the relative degree of availability of social agencies as between the small and large town. There many agencies exist, more people tend to use them. In small towns, where relatively few agencies exist, people requiring the services of health and welfare agencies will probably tend to go without them to a greater extent than will their big-city friends.

The above contention, if valid, implies that many of the thirty-nine families now unknown to social agencies might well have used them



more had there been more of them to use.

It would appear that a personal interview with such men might prove of value, in the light of the above discussion, in either verifying or disproving some of their suspected disabilities.

To digress for a moment, the size of the families was known for thirty-six of the fifty-two cases with police records (69%). The median number of children per family among these was 6.6! This fact can readily inspire fascinating socio-economic speculation.

D. AMOUNT OF SERVICE PROVIDED BY SOCIAL AGENCIES TO THESE CASES

The following data will reveal the extent of the service provided by social agencies throughout the state to a relatively unselected group of people; unselected, that is, in the sense that they were not chosen to be referred because they were regular users of these agencies.

TABLE XII
NUMBER OF CONTACTS WITH AGENCIES

Clients	Number	Number of Contacts	Number of Agencies
Selectees	35	63	25
Families	50	298	85
Together	61*	361	94**

* Cf. TABLE VIII, p.50, and explanation of it.

** Selectees and families sometimes used same agency.

The above table shows that ninety-four different agencies provided service to the sixty-one families known to them, that the families used these agencies about six times on the average, and that they used an average of $1\frac{1}{2}$ different agencies.

The distribution of these agencies in the public and private field



is next shown:

TABLE XIII
NUMBER OF PUBLIC AND PRIVATE AGENCIES KNOWN

Known By	Public	Private	Total
Selectees	11	14	25
Families	31	54	85
Together	32	62	94

It is clear from the above data that families used more private agencies in relation to public than did selectees.

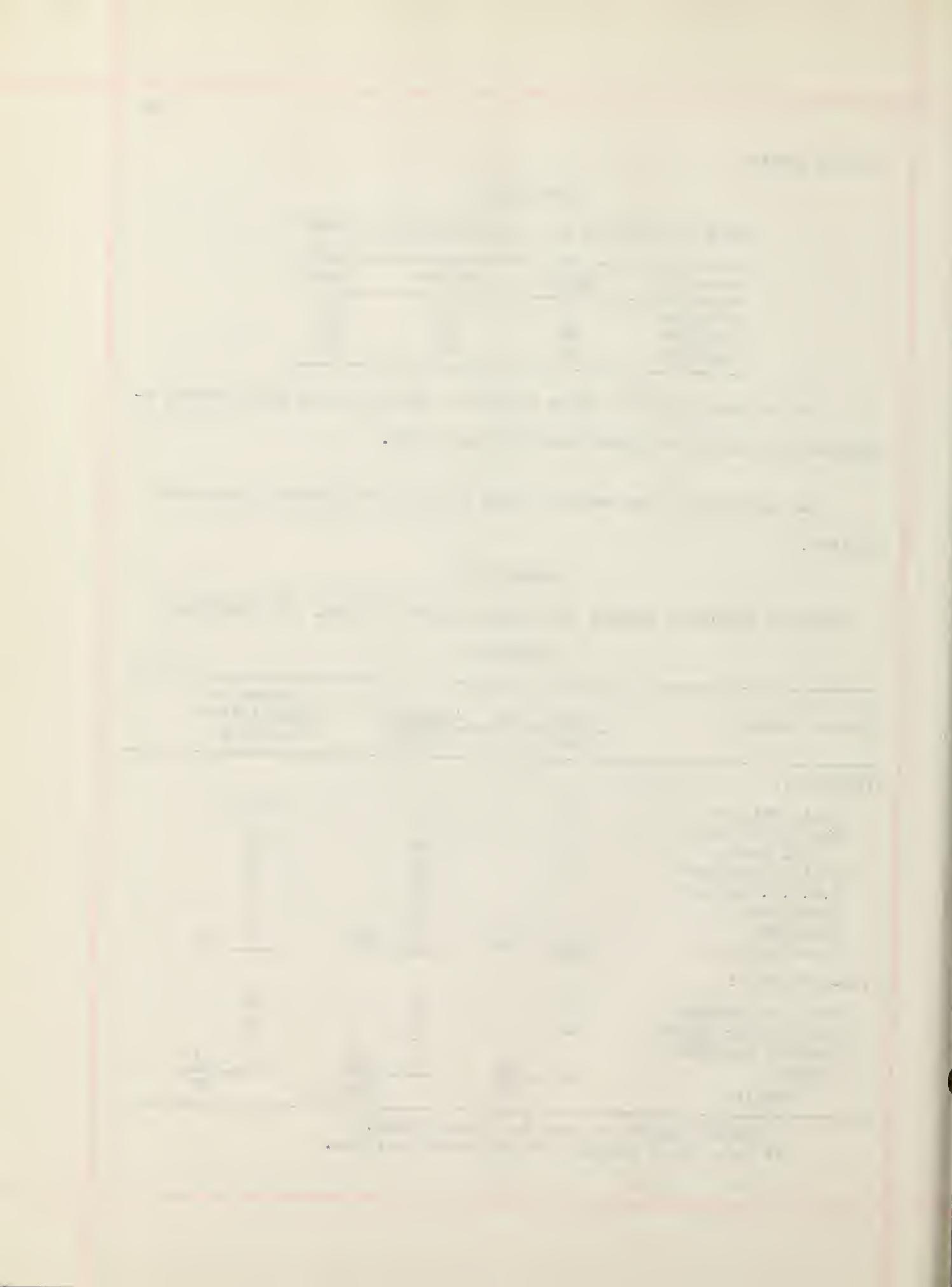
An analysis of the various kinds of services offered by agencies follows:

TABLE XIV
TYPES OF AGENCIES, NUMBER OF FAMILIES KNOWN TO THEM, AND NUMBER OF CONTACTS*

Type of Agency	Number Man	of Family	Contacts	Number of Unduplicated Families
VOLUNTARY:				
Child Welfare	3		28	20
Family Service and Relief	25		58	32
Health Service**	10		68	32
S.P.C.C. Offices			15	9
Group Work			1	1
Research			2	2
Miscellaneous	1	39	173	2 47
TAX-SUPPORTED:				
City Departments	9		63	33
State Departments	13		46	32
Federal Agencies			1	1
Courts	2	24	15 125	15 51
Totals		63	298	61

* Classification as used by Boston Index.

** Only cases passing through social service.



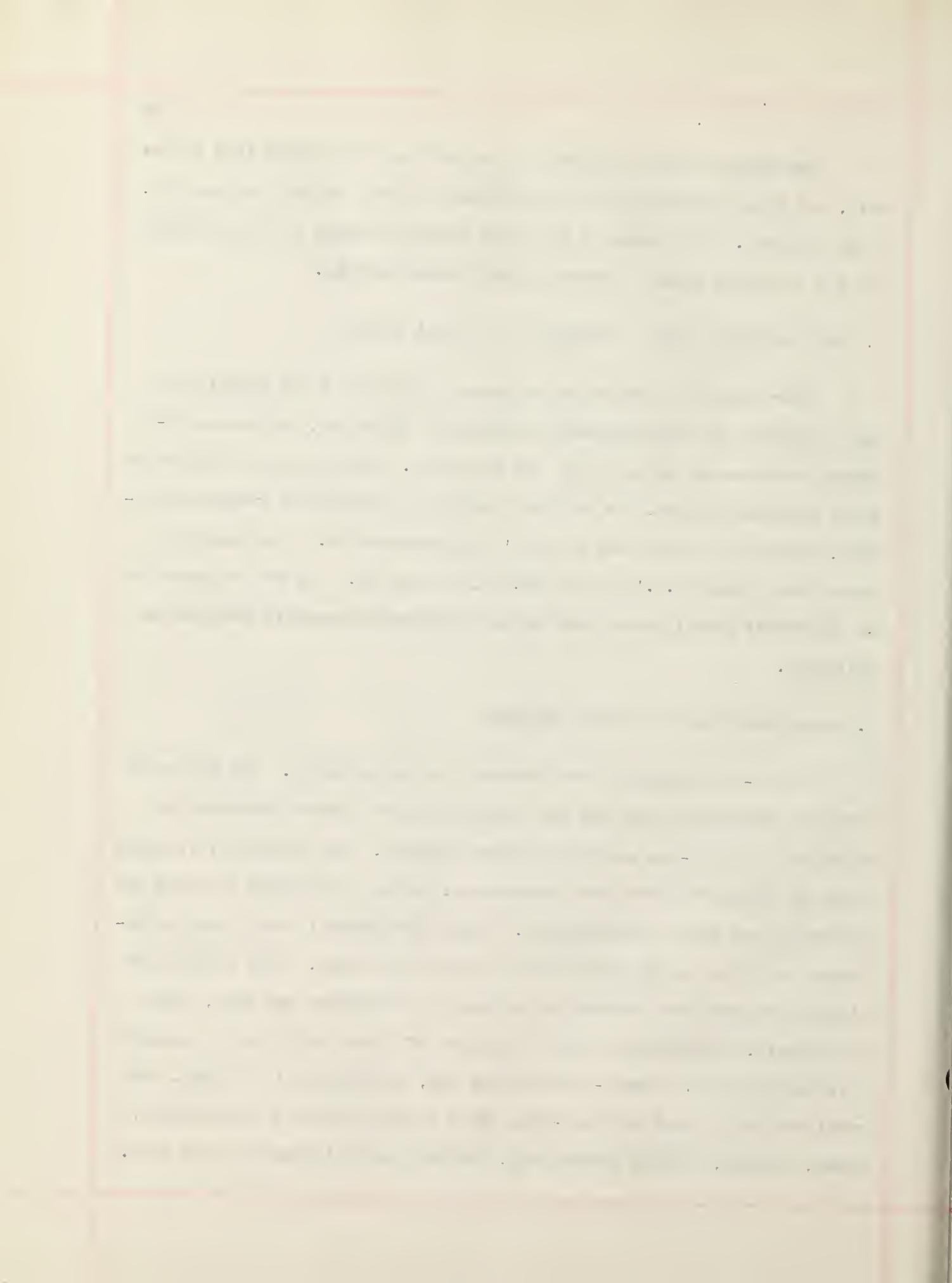
The social workers checked the records on 177 contacts (49% of total), and found psychiatrically significant material in half of them (88, to be precise). This seems to be a good batting average fully justifying the use of social agency records in such investigations.

E. DATA GATHERED THROUGH DEPARTMENT OF MENTAL HEALTH

Four selectees were known to mental hospitals in the state; two were diagnosed as Constitutional Psychopathic Inferiors, and two as Dementia Praecox--one paranoid and one catatonic. Four had been examined in child guidance clinics, one had been tested in a school for retarded children, and one had been given a Brigg's Law examination. The results of these tests showed I.Q.'s of 85, 84, 80, 67, and 53. One was diagnosed as of low normal intelligence, and one had exaggerated neurotic behavior in childhood.

F. DATA FROM POLICE AND COURT RECORDS

Fifty-two selectees were arrested for 401 offenses. The number of offenses committed by any one man ranged from one offense committed by eight men to sixty-one committed by one selectee. The three most frequent types of offenses listed were drunkenness, larceny (including breaking and entering), and minor delinquencies. There were several other types of offenses not quite so frequent as the three listed above. Some of the more significant ones for psychiatric purposes were lewdness and rape, fraud and forgery, and operating under influence of liquor and so as to endanger life and property. Twenty-eight of the men, just over half of them, were committed for a total of forty-nine times to the following institutions: Lyman, Shirley, Concord Reformatory, Norfolk, and Bridgewater State Farm.



G. EVALUATION OF DATA

The director of the social service investigation, Miss Wyman, then evaluated the material in each social history in terms of Army standards for rejection. Hence her conclusions probably approximate pretty closely those which an Army induction board neuropsychiatrist might make on the strength of the same evidence. Each case was labelled either conclusive, useless, or suggestive. All histories on which Miss Wyman felt sure the man should be rejected were termed conclusive, i.e. the evidence in them was, in her considered opinion, conclusive. Conversely, all those in which there was no evidence at all or none of any psychiatric significance were called useless. Those with significant indications which could not be safely evaluated without additional information were termed suggestive.

The hundred cases were divided among the three groups as follows: conclusive--21, suggestive--37, and useless--42. Thus one-fifth of the cases were considered rejectable on the strength of the evidence gathered by means of an investigation of recorded data only, without follow-up interviews. Over a third of the cases contained significant material which, if augmented by other data, might well have become conclusive. A number of the useless histories contained no data at all because the selectees were not known to any of the sources consulted. This does not necessarily mean, however, that their histories are negative.

The chief evidence on the strength of which twenty-one histories were labelled conclusive is here presented:



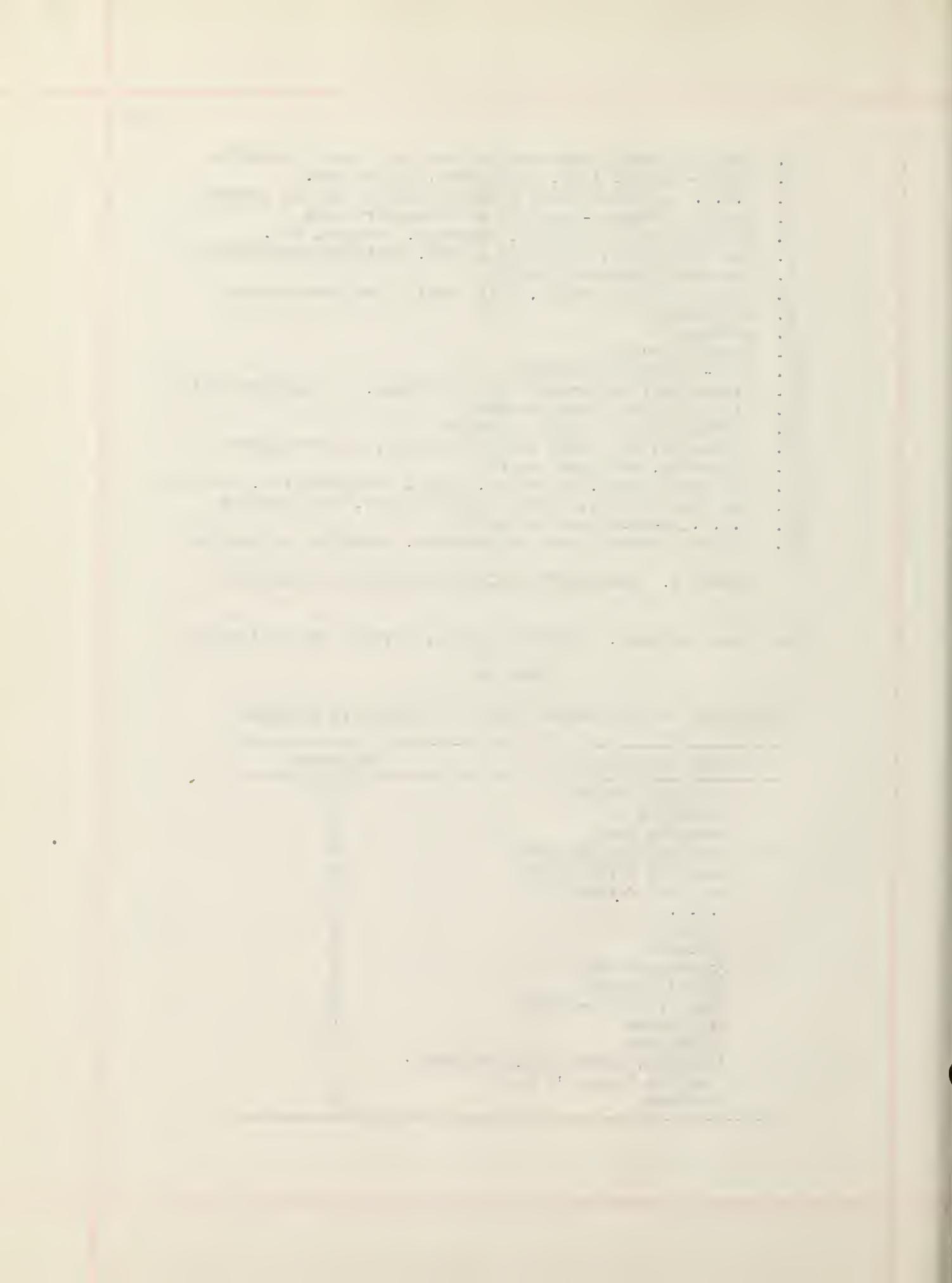
1. Constitutional Psychopathic Inferior, lewd, alcoholic
2. Feeble-minded, lewd, malingerer, old Chorea.
3. C.P.I., confessed many breaks, question of sex pervert
4. Dementia Praecox-paranoid at Worcester State
5. Unstable boy and family, enuresis, truancy, etc.
6. Bad background, bad court record, unstable personality
7. Dementia Praecox-catatonic
8. Very poor environment, dull, easily led into trouble
9. Alcoholism
10. Epilepsy
11. Anxiety neurosis
12. Post-traumatic epilepsy
13. Alcoholism, bad record, unstable home, incompetent family
14. Alcoholic, bad court record
15. "Mother's boy," social disease
16. Alcoholic, bad court and work record, mother psychotic
17. Alcoholic, bad work record
18. Bad work record, chiseller, social disease-cured, divorced
19. Bad court record, juvenile delinquency, sex problems
20. C.P.I., a-moral and a-social
21. Bad work record, much delinquency, unstable personality

FIGURE 2. CONCLUSIVE EVIDENCE FOUND ON 21 SELECTEES

The above evidence, when broken down, reveals the following:

TABLE XV
FREQUENCY OF THE VARIOUS TYPES OF CONCLUSIVE EVIDENCE

Type of Evidence	Frequency
Bad court record	9
Alcoholic	6
Unstable home	5
Lewd and sex problems	4
Unstable personality	4
Bad work record	4
C.P.I.	3
Psychotic	2
Epileptic	2
Psychoneurotic	2
Social disease	2
Dull or feeble-minded	2
Old Chorea	1
Malingerer	1
Immature, effeminate, dependent; called "mother's boy"	1
Divorced	1



The thirty-seven suggestive histories were divided as follows:

TABLE XVI
TYPES OF SUGGESTIVE EVIDENCE

Type of Evidence	Frequency
Significant data on home, none on selectee	12
Significant data on selectee, none on home	14
Significant data on both selectee and home	11
Total	37

The figures above show that significant material was known on selectees in twenty-five cases, and on their home environment in twenty-three cases. In the twelve cases in which a poor home environment was indicated, it is important to determine the effect of this environment on the emotional and social adjustment of the selectees concerned. Analysis of the data on the home environment in these twelve cases reinforces the above contention. Four of these selectees had either one or two psychotic parents, one had a psychotic sibling and came from an "easy-going" family, six came from unstable homes, and one had two paretic parents.

To what extent has the evidence in these social histories confirmed or failed to confirm the suspected disabilities listed in the reasons for referral?⁵

The conclusive histories definitely confirmed the known corresponding referral causes. The suggestive and useless histories, however, did not conclusively confirm the reasons for referral of the men they describe. A glance at those referral causes which were not confirmed reveals some significant facts:

3 Cf. TABLE IV, p.47.

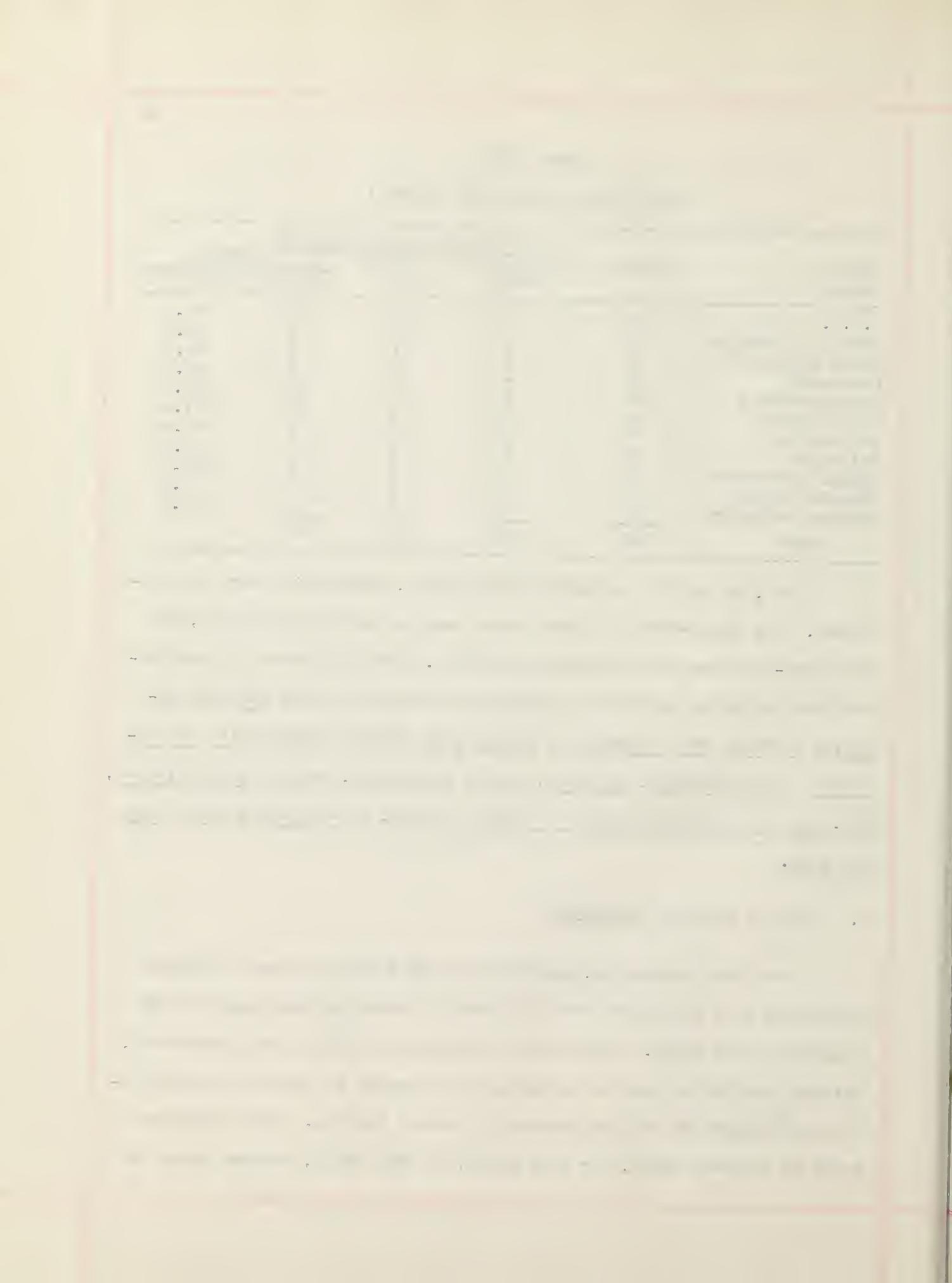
TABLE XVII
UNCONFIRMED REASOS FOR REFERRAL

Referral Cause	Number	Number Unconfirmed By			Together Number	Percentage
		Suggestive Data	Useless Data	Number		
C.P.I.	13	7	3	10	76.8	
Chronic alcoholic	9	7	1	8	88.8	
Acute alcoholic	3	1	1	2	66.7	
Psychosis	8	1	4	5	62.5	
Psychoneurosis	10	4	6	10	100.0	
Court record	14	8	2	10	71.4	
Malingering	7	2	3	5	71.4	
Epilepsy	13	3	9	12	92.2	
Mental deficiency	3	1	2	3	100.0	
Organic defects	9	2	5	7	77.8	
Unknown aetiology	13	6	7	13	100.0	
Total	102	42	43	85		

Thus, of the 102 suspected disabilities, eighty-five were not confirmed. For forty-three of these there were no useful data at all, and for forty-two there was suggestive material. The high rates of total unconfirmed referral causes are alarming, for they mean that the vast majority of those men suspected of having such serious disabilities as psychosis, psychoneurosis, epilepsy, mental deficiency, organic nerve disease, etc. may, if no further data be secured on them, be accepted shortly into the Army.

H. NEED FOR PERSONAL INTERVIEWS

The above evaluation, particularly TABLE XVII, indicates clearly that there is a vital need for additional information about many of the selectees under study. Since known recorded data have already been used, the only available means of gathering new material is through personal interviews handled by skilled psychiatric social workers. Such interviews would be of great value, for they would, in many cases, produce clues for



further investigation of such vital sources of information as teachers, employers, and family physicians. By tapping these three sources, much information could be obtained about such psychiatrically significant items as work histories and habits, adolescent problems and behavior, mental capacity, past and present health, both physical and mental, etc.

Recognizing all this, the director of the social work project, in her reports on individual cases sent to the Chief Medical Officer, State Selective Service System, recommended personal interviews for seventy-five of the hundred selectees. In thirty-five of these cases, such an interview was held to be important.



CHAPTER VI

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

A brief recapitulation of the most salient points highlighting this study will help to weave the several threads of argument into a compact, readily-discriminable pattern.

The strains and stresses of modern war with its "blitz" techniques and its abundance of mechanical devices require a fair measure of mental capacity and emotional stability, as well as physical stamina, of those who engage in it. Emotionally or mentally unfit men have no place in a modern army, for conditions of military training and combat present peculiar psychologic hazards which, as the last war showed, evoke all the latent mental and nervous disabilities in these vulnerable individuals. Such men should not be accepted by the Army, because induction would, in most cases, produce disastrous consequences: much valuable time would have been lost in the wasted training of these men; discipline and morale in the armed forces would suffer severely; the lives of many of these men would be wrecked beyond repair; and most of them would ultimately become a burden to themselves, to their families, to their communities, and to the federal government. Permitted to remain in civil life, many such men could continue to lead socially useful lives. When it is recalled that the U.S. Veterans' Bureau has already spent a billion dollars for the treatment, care, and maintenance of the neuropsychiatric casualties of the last war, then we begin to realize how dearly we have paid for our carelessness in the selection of military personnel in that war.

Recognizing all this, the National Selective Service System has



shifted its emphasis in this war from weeding out gross misfits to sifting in only those men who are vocationally fit for war. Under the present system, however, it is impossible to do this job adequately. Full responsibility for detecting neuropsychiatric disabilities in candidates for induction now rests with induction board psychiatrists. And they are able, due to pressure of time, to give an average of only six minutes to each case. Without some social-historical data on these men, the psychiatrists cannot hope to detect much more than the gross and obvious defects, thus permitting thousands of potential nervous and mental casualties to enter the armed forces.

A number of State Selective Service Systems, become aware of the value of this social-historical data, and learning that this material was readily obtainable from the records of social agencies and other community resources, have adopted social service investigations of these records as a routine part of the neuropsychiatric examination.

The Massachusetts Selective Service System recently authorized a one-month experimental psychiatric social service investigation of the recorded data on a hundred-odd men temporarily rejected by induction boards because of suspected neuropsychiatric disabilities, and also on a few hundred men selected at random. The latter study was to be for the purposes of research. Apparently this experiment proved fruitful, for within a month of its completion one Boston local board was requested to adopt a routine investigation of all its l's.

The hundred social histories gathered in the experimental study mentioned above were studied and analyzed by this investigator under the expert guidance of the director of the social work project. The results

showed that twenty-one of the men should be rejected on the strength of the evidence contained in their records; that on forty-two of these men there were no significant data available; and that thirty-seven of them showed significant tendencies in their histories. Before a diagnosis could safely be made on these latter men, further information would have to be obtained. Hence the director of the project requested personal interviews with three-quarters of these selectees.

On the basis of this study, the investigator recommends that a psychiatric social service investigation of all selectees in class 1 be adopted as a routine part of the local board "screening" examinations throughout the state, and that personal interviews with selectees be authorized whenever these are considered necessary. In this way, selectees with significant social histories can either be rejected immediately by their local boards, or else this material can accompany them when they appear at the induction board for examination. Current experiences in other states have shown conclusively that armed with such material, psychiatrists tend to detect a much greater proportion of disabilities than otherwise.

Thus, with the help of social service investigation, psychiatry can make a significant contribution to the national defense by helping to mobilize a fighting force of the finest human calibre that this country can produce.



APPENDIX

NEW ENGLAND DIVISION OF PSYCHIATRIC SOCIAL WORKERS

My dear

The New England Division of Psychiatric Social Workers has been requested by Colonel Currier of the Selective Service to organize and furnish psychiatric social work service for one month on a voluntary basis, after which it will probably become an integral part of the examination for men inducted into the Service. This will entail an interview with each man for whom the neuro-psychiatric examiners ask a study, and a search of agency records for information which will help in their decisions about his acceptance or rejection for military service.* This help from us is requested for the month beginning Monday, January 5, 1942.

A second study, mainly research in character, has also been requested. For it we will study every tenth man or approximately 800 of the 8,000 who will come for examination during the month. This will be only a study of the records, usually without an interview, and its purpose is to determine how valuable it might be to include such a study routinely in all Selective Service examinations. The impetus for this request came specifically from the wishes of Colonel Currier and Dr. Bloomberg, who is in charge of procuring neuro-psychiatric examiners for the Boston Induction Center. However, they received the sanction they needed from their national headquarters before they made the request, and we are sure that the work Dr. George Stevenson of the National Committee for Mental Hygiene and the psychiatric social workers of New York and Hartford and other groups have done has made it possible for such sanction to come. This second, or research project is, we think, the first one of its kind which has been undertaken, and Dr. Bloomberg expects that the results of it will profoundly influence the national Selective Service Board in its decisions later as to the use of social work service, psychiatric or medical, in the future induction of both enlisted and selected men. The screening out of men who are not sufficiently stable emotionally to withstand the pressures of war is a very vital problem to the army and to us as psychiatric social workers. The estimated cost to the United States Government for neuro-psychiatric patients whose break-downs are related to their military service in the last War has averaged \$30,000, a stupendous sum. Adding to this the human values involved for the men and their families, we cannot doubt the importance of making

*It is difficult to know in advance what the volume of this task will be, but it is estimated at 2% of the candidates, or 160 for the month.

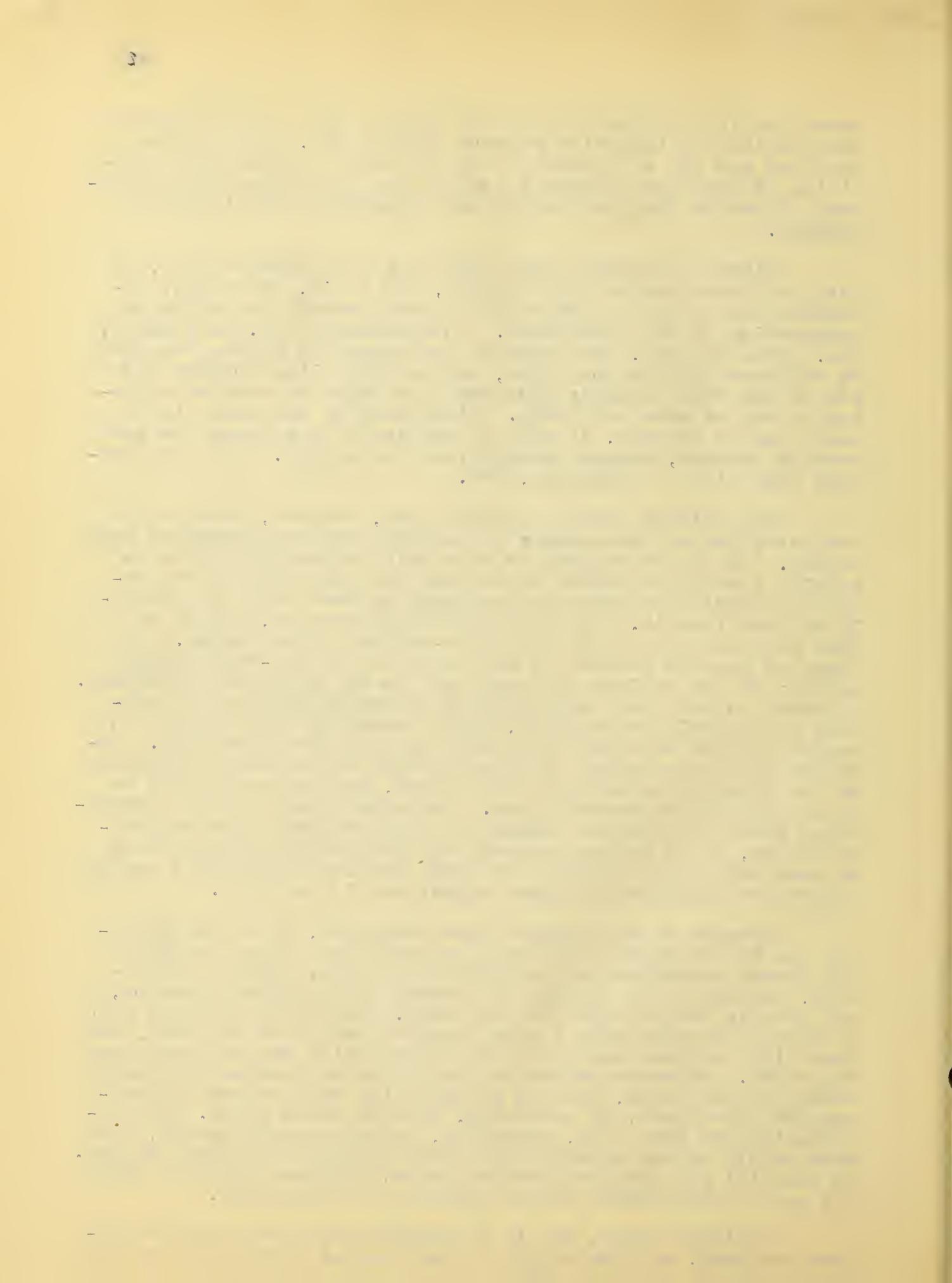
every possible effort to avoid at least a part of the mistakes made during the induction process in that War. We are sure that you are all as pleased as we are that the New England Division of Psychiatric Social Workers has been given the assignment of making the study which may accomplish this important purpose.

Since the request only came to us on December 27th, it has been necessary to plan quickly, and it is, of course, necessary that all the work shall be done through the voluntary cooperation of our membership. Four workers, Mrs. Mary Burke, Mrs. Franc Nichols, Miss Bernice Henderson and I have been able to volunteer half of our time, and we would like to hear from you or any other members whom you find might be able to volunteer a day or more each week. Since much of the work will be searching of records, it will be difficult to arrange for much evening service, except through your own agency. But some evening work will be necessary, too.

The primary service you can give, however, will be in reviewing for us the records of men who have been known to your agency. We are asking you to take this responsibility or to appoint some other member of the New England Division of Psychiatric Social Workers also employed on your staff or recently retired from it. This letter is mimeographed, but is no less personal than if it were hand-written to you alone. The forty of you who receive it are to be the agency-cooperating members of the Project and your service to us is very important. In order to make our demonstration of psychiatric social service as valuable as possible, it is essential that the work of evaluating the material in records be done very carefully. Enclosed with this letter are some Working Notes with a statement of the types of information we can use, and the way it can be most usefully presented by you. The appointment of this cooperating group of Division members in the agencies seems economical to us, since you can extract the particular information we need much more quickly than could another psychiatric social worker not familiar with your agency and its records.

Because of the limited time available, it is not possible for the directing committee to take this matter up with the agency executives as we would like to do. We are, therefore, asking you to discuss it thoroughly with your Director, and ask his cooperation for our study. We are fortunately able to assure you that only a very short report is to be given, and that will be given orally to the psychiatrist who has requested the study. No other person at the Selective Service will have access to our notes, and the psychiatrist will record his reason for deferral, if necessary, only in broad terms. The information you give will, therefore, be quite confidential, and used mainly by the psychiatric social worker at the Unit office. As you will see from the Working Notes, intimate material about the man's relationship to the agency is not required.

Estimates vary, but it is probable that only ten to fifteen per cent, or from eighty to one hundred twenty men, in the



research group will be identified by the Central Index. (Deferrals for causes of "dependency" will be made before the men come for the medical examinations, and will not be included in our study.) Therefore, the number registered by your agency will not be too great a burden, we hope. Because of the short time we have for the total study, we are asking that you send us your report within forty-eight hours of the time we request it from you. This will doubtless require either that you be freed for some day time work, or that you do the work in the evening as your voluntary contribution to the Project.

Will you please write Marian Wyman at once, care of Selective Service, Psychiatric Social Work Unit, 269 Columbus Avenue, telling her whether you or some other member of your staff will act in the capacity of Co-operator to the project?

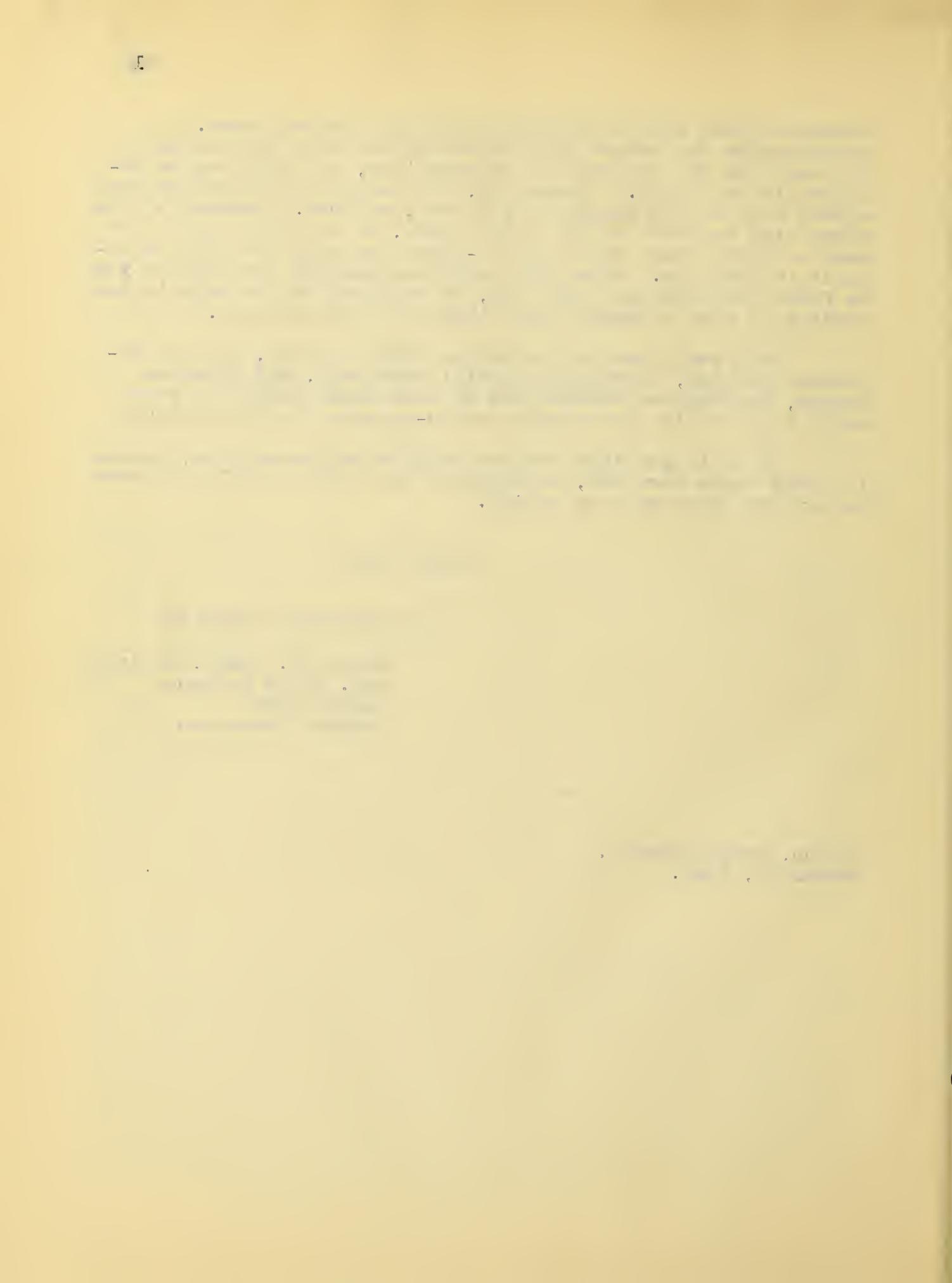
If it is possible for you to give any other time, please let Miss Wyman know too, as we shall need more social work than we have yet been able to enlist.

Yours truly

THE DIRECTING COMMITTEE

Marian M. Wyman, Chairman
Mrs. Maida Solomon
Esther Cook
Fernice Henderson

Boston, Massachusetts.
January 2, 1942.



TO THE CO-OPERATIVE WORKERS IN AGENCIES
NEW ENGLAND DIVISION OF PSYCHIATRIC SOCIAL WORK

This is to let you know that the office of the Psychiatric Social Work Unit, Selective Service, is finally definitely established at 38 Chauncy Street on the eleventh floor. This is the executive headquarters of the Massachusetts State Board. Our telephone number is Liberty 8073. The work we planned to start on January 5th did not actually get under way until the 8th and there are some changes in the plan. For the time being we are not having routine interviews with selectees, though I think we can make arrangements for individual cases when it seems necessary. We will, however, have referrals from all four induction centres (Springfield, Camp Devens, and Providence, which covers southern Mass. as well as the Boston Centre), and we expect that this group will be much larger than we indicated in our first letter.

Enclosed are the working notes we promised you. We have made an attempt here to indicate the main points we need to know, but I am sure as you review cases for yourself you will find other points which are helpful. You may either telephone us your reports or send them to us by mail, whichever seems more convenient to you. When your record gives nothing pertinent to the study of the selectee himself, you need give us no detail at all but simply state that fact.

We have received enthusiastic responses from everybody and are pleased at the number of you who have offered service in excess of your agency coverage. We have not enough work so far at the Unit to need any extra help, but within a few days we will be under way on cases, so that I am sure we will be calling on you for your help.

Marian M. Wyman
Director
Psychiatric Social Work Unit
Massachusetts State Board of
Selective Service

Material to be obtained from Mental Hospitals and out-patient departments of mental hospitals and psychiatric out-patient departments of general hospitals.

1. Dates of hospitalizations

2. Diagnoses

If non-psychotic - chief symptoms - reason for admission, i.e. Some clients are admitted because of environmental difficulties. Adolescent boys are admitted frequently because they rebel against dominant, neurotic, psychotic parents. Hospital residence or study in clinics should not be held against them.

3. Exaggerated neurotic traits - which have persisted through adolescence.

(Early developmental histories are of little value uncorrelated with later disturbances.)

4. School maladjustments

Reasons for failure (watch out for non-reading as a cause. Should not be held against child.)

5. Intelligence quotients. In hospital, clinic or school.

(Always ask if "valid"--many social workers are apt to use just total findings, not noticing psychologist's comments.)

6. Work history. Types - Changes - Reasons for same. Employer's opinions- (often recorded in hospital records.)

7. History of drinking or drug indulgence. (May be a record of this even where there have been no arrests.)

8. History of sexual misconduct. Type. Frequency.

9. Physical Difficulties - Injuries. (Dates.) Results of physical examinations - emphasis on neurological findings - heart, lungs, kidney (diabetes) G.I. upsets. Positive blood - spinal fluid. Gonorrhea.

10. General Personality Traits. Impulsive, unstable, temper tantrums, easily upset, seclusive, very changeable.

11. Family History of Mental Illness.

12. Consensus of Informants as to main characteristics.

Child Guidance Clinics - Habit Clinics - and Children's Agencies

1. Exaggerated Neurotic Traits. How long existed? When?
2. Delinquencies. Types? Arrests? To what related (Truancy, school difficulties.)
3. School Difficulties. Reading disability should not be held against one nor should language difficulties.
4. Any and all intelligence quotients (but distinguish between "valid" and "non-valid" results.)
5. Physical History. Long illnesses - chorea - Positive bloods. Injuries. (Detailed developmental histories not necessary)
6. Home Situation. Are personality traits of stubbornness, rebelliousness, etc. related to cultural repressions, strictness, poverty. If so, not fundamentally bad.
7. General personality traits. Impulsivity, unreliability, temper tantrums, great seclusiveness.
8. Type of improvement after social service contact. If change (improvement) of personality came after change in environment, fundamental traits probably O.K.

Medical Agencies - Community Health Agencies

1. Dates of contact (Correlate with age of child)
2. Diagnosis (Ask always regarding T.B., diabetes, heart disorder, head injuries.)
3. Neurotic Traits. Exaggerated ones.
4. Queer behavior.

Family Agencies

1. Family History of Mental Disease.
2. Has child ever been diagnosed as mentally ill, queer, neurotic?
3. Delinquencies? Juvenile, Alcoholism, Sexual difficulties.
4. Arrests?
5. Long illnesses - diagnoses.
6. School records.
7. Work history.

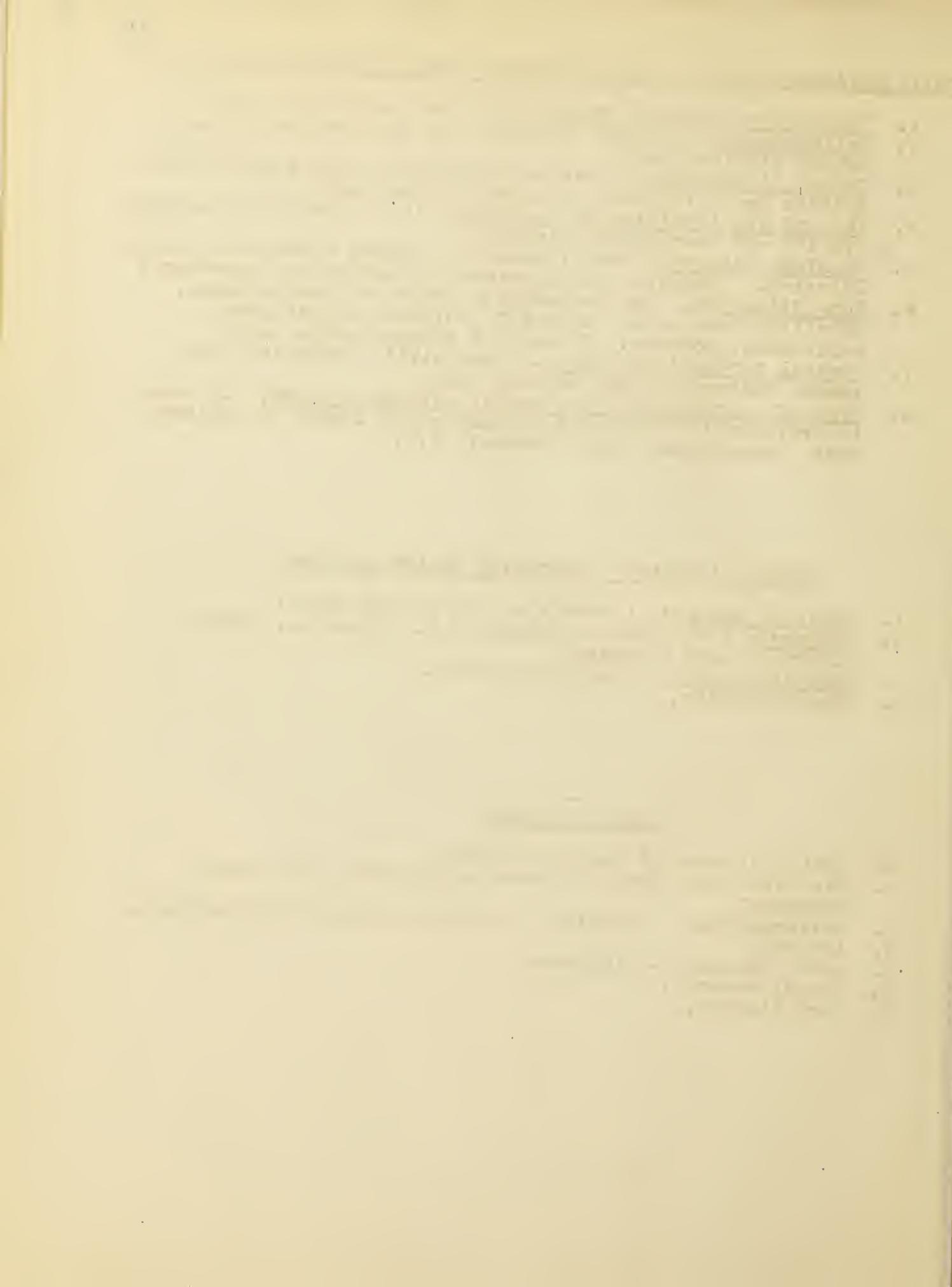


FIGURE 6. RECORD FORM KEPT ON EACH CASE

MASSACHUSETTS STATE HEADQUARTERS
FOR
SELECTIVE SERVICE

LIB. 8073

38 CHAUNCY STREET
BOSTON, MASS.

February 16, 1942

TO LT. COLONEL DONALD CURRIER

Report of Psychiatric Social Work Study, Case # S-000

Board # 000

Doe, John Q., Age 24
58 Branch Road, Boston, Mass.

Boston Social Service Index:

We do not find any records of Social Agencies who have known Selectee or his family, except that the Red Cross had a report of a civilian contact in 1942. Their record had been destroyed as it held nothing of importance.

Mass. State Probation Board:

In '21	Gaming L.D.	-Fine, \$5.
In '21	Drunkenness	-Released
In '22	"	-Rep. parole officer
In '23	"	-Fine, \$5. S.S.
In '23	"	-Prob. 1 yr.
In '23	Violation of auto law	-Fine, \$100. default
In '23	" " " "	-Filed
In '24	Rape	-Waived exam. 6 mos. H.ofC.
In '24	Violation of auto law (default)	removed-Paid \$100.
In '24	Larceny	-1 yr. H.of C.
In '31	Drunk	-\$5. SS

Mass. Department of Mental Health:

No Report

N.B. We do not know how to evaluate the large amount of delinquency in Selectee's earlier history, since he has no record since 1931. A psychiatric social work interview with him would probably yield clues for further investigation as to his adjustment.

Marian M. Wyman,
Director, P.S.W. Unit

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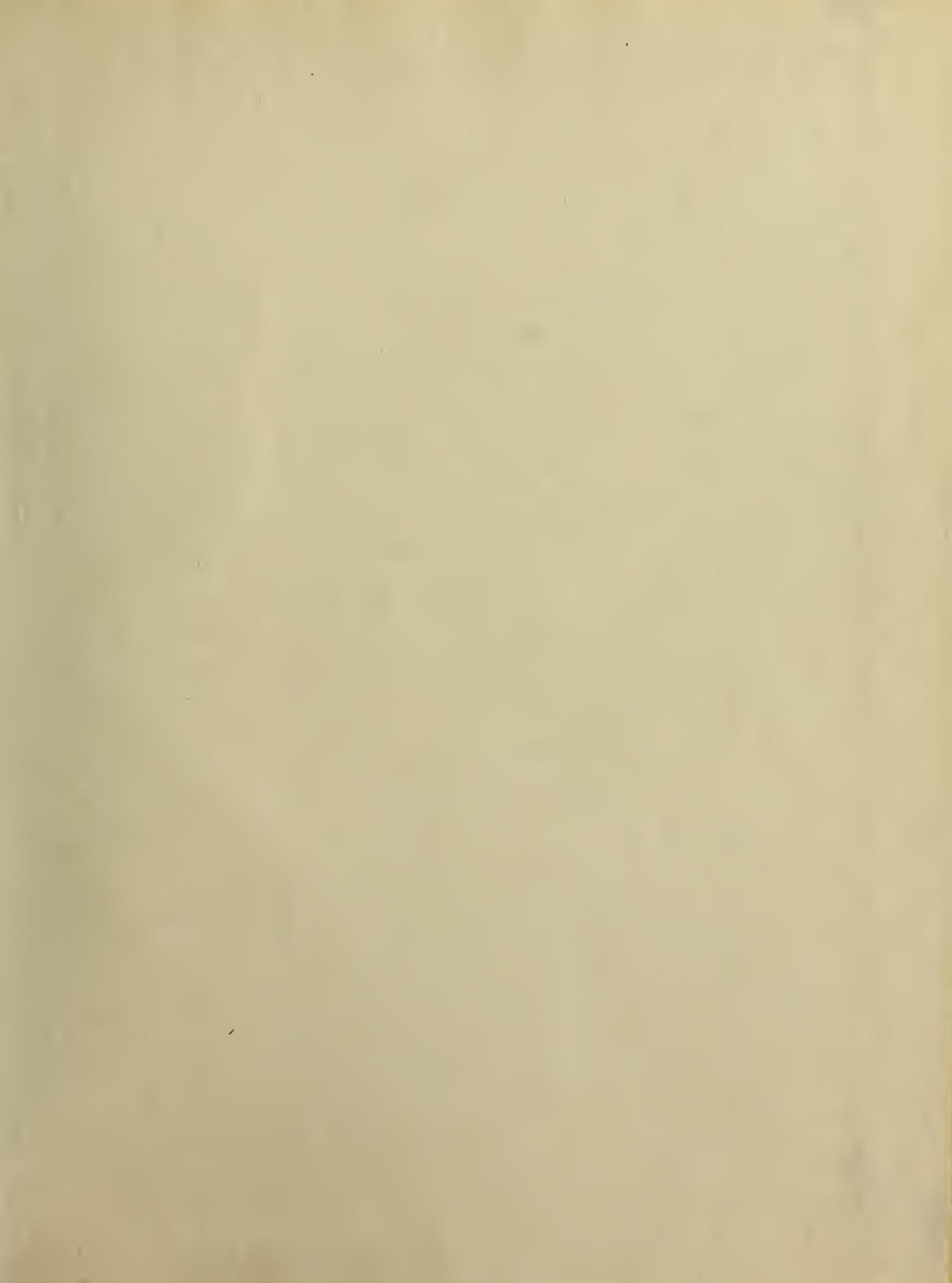
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